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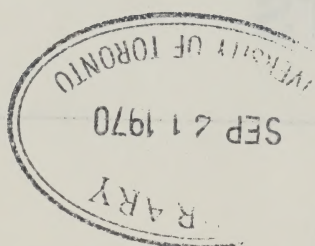
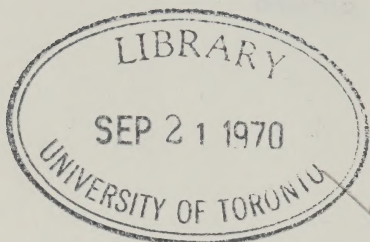
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ONTARIO

COMMITTEE ON THE HEALING ARTS

REPORT 1970





ONTARIO

COMMITTEE ON THE HEALING ARTS

VOLUME 2

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Chapter 7 Hospitals

Ontario has 316 institutions bearing the name "hospital".¹ This term covers a range of health institutions, a range so broad as to cause one authority to remark that in general the term "hospital" has become more or less meaningless.² Hospitals differ markedly in size, functions and ownership; consequently, they may be classified in a variety of ways, all of them arbitrary and some of them more useful for some purposes than others. We shall provide here a brief initial review of the types of hospitals in the provinces. Our discussion in the body of the chapter, however, will bear upon the institutions subsumed under the rubric "public general hospital".

In discussions of hospitals in Ontario the most frequently encountered classification is that found in the regulations made under the Ontario Public Hospitals Act.³ These regulations classify hospitals in Ontario according to the following schedule: Group A hospitals are large general hospitals providing facilities for the teaching of medical students; Group B comprises smaller hospitals of 200 beds or more, or of fewer than 200 beds if located in a municipality in which there is no Group A hospital; Group C hospitals are those having fewer than 100 beds, and located where there is no Group A hospital.

As noted, these A, B and C hospitals are those with which we will be chiefly concerned in this chapter. They are the public "general" hospitals providing active treatment, the kind of institution which most of us probably think of when the word "hospital" is used in general conversation.

There are, however, a number of special purpose hospitals to which some reference should be made. They too are graded by letter: Group D hospitals are Red Cross outpost hospitals; Group E are convalescent hospitals; Group F hospitals are large chronic care hospitals having more than 200 beds; Group G, smaller chronic care hospitals; Group H are psychiatric hospitals having teaching facilities for medical students; Group I hospitals treat alcoholics and drug addicts; and Group J hospitals are those authorized by the Ontario Hospital Services Commission to provide in a designated region special rehabilitation services for disabled persons.

¹See *Canadian Hospital Directory*, 1969, p. 17.

²See K. Evang, "Political, National and Traditional Limitations to Health Control", in *Health of Mankind*, Ciba Foundation 100th Symposium, pp. 209-211.

³O. Reg. 364/67, Classification of Hospitals, made October 12, 1967.

2 Hospitals

In 1969, Ontario had 316 hospitals with a total of 71,400 rated beds.⁴ Some 68,100 beds were set up for use and these can be classified by the type of service they provide: general beds made up about 55 per cent and mental beds about 29 per cent of the total number of beds set up; the remaining 16 per cent were made up of contagious, chronic, convalescent, tuberculosis and orthopaedic beds.

Hospitals may be classified not only according to function, but also according to ownership. Hospitals have developed in Ontario under a wide variety of auspices. Forty-three of the 316 hospitals referred to above are privately owned; with the exception of private sanatoria, these institutions are regulated under the Private Hospitals Act.⁵ These are mostly small institutions, providing some 1,800 of the province's 71,400 beds. Next in order of magnitude are the hospitals operating under the auspices of the federal government. There are ten of these, providing a total of over 1,700 beds, most of which are found in two Department of Veterans Affairs hospitals. Municipal governments operate twenty-four hospitals, representing approximately 6,300 beds. The Government of Ontario operates twenty-seven hospitals, providing roughly 20,400 beds, of which almost 82 per cent are set up in mental hospitals, institutions which are usually referred to as "Ontario Hospitals". Religious groups operate fifty-seven hospitals with a total of approximately 13,000 beds. The remaining 198 hospitals are operated by voluntary corporations and other lay bodies. These "voluntary" hospitals provide about 30,100 beds, making this the largest category in terms both of number of institutions and number of beds.⁶

The lay and religious hospital beds are predominantly "general" beds. Approximately 32,700 of the total of 38,000 general beds are in either lay hospitals or religious hospitals.

Hospitals in Ontario vary widely in size. The provincial government's mental hospitals are large; in the twenty-six institutions of this type there are over 17,000 beds. The federal hospitals also are large. Private hospitals are generally very small institutions.

⁴All of the following statistics are taken from the *Canadian Hospital Directory*, 1969. There are discrepancies between these figures and those given for hospital facilities in Chapter 6. Note that different sources are used which are based on different methods of classification.

⁵The "private hospitals" regulated by the Private Hospitals Act, R.S.O. 1960, c. 305, are those institutions in which four or more patients are or may be admitted for treatment, other than,

- (i) a hospital or other establishment or institution supported in whole or in part by provincial aid,
- (ii) an institution in respect of which a licence under the Private Sanatoria Act is in force,
- (iii) an institution for the reclamation and cure of habitual drunkards established under the Municipal Act,
- (iv) a house registered under The Maternity Boarding Houses Act,
- (v) a lodging house licensed under a municipal by-law.

Private sanatoria are regulated under the Private Sanatoria Act, R.S.O. 1960, c. 307.

⁶Since there is some overlap in these categories (specifically, the hospitals in the "private" category are also included in the classifications "lay" and "religious" as appropriate), the figures given in this paragraph do not tally with the overall total of 316.

The greatest range of sizes is found among the general hospitals. Some of these have fewer than ten beds. At the other end of the scale, the Toronto General Hospital is enormous. Toronto General has 1,277 beds and 128 bassinets. During 1967 it admitted over 27,000 patients. It employs almost 3,500 persons, whose salaries comprise a large part of the twenty-four million dollar annual budget.

There are twenty large public general hospitals in the province, each with more than 500 beds; together they represent 14,800 of the 39,700 beds set up in all public general hospitals. There are also eighty-eight public general hospitals with fewer than 100 beds each, which together represent approximately 4,300 beds. In between are ninety public general hospitals ranging from 100 to 499 beds; these account for approximately 20,500 beds.

As would be expected, the size of a hospital tends to correspond to the size of the community in which it is located. Thus we find the very large general hospitals located in the metropolitan centres of Ontario, the smallest hospitals scattered through the hinterland, and in between these, the medium-sized hospitals characteristic of the relatively large urban communities.

A system of interdependence has evolved which links the larger and smaller hospitals together in a workable but still informally organized pattern. As specialized treatment facilities are developed in the large centres, patients are more and more frequently referred from the smaller hospitals to the larger. These larger hospitals tend to associate themselves with particular metropolitan teaching hospitals, which are in turn related to the five medical schools in the province. The medical schools supply the hospitals in their orbit with the most highly specialized kinds of treatment personnel. In return, the hospitals provide the medical schools with the large range of varied types of illness required for the clinical training of their students. One consequence of this interaction is that the metropolitan hospitals tend to become increasingly large and complex, oriented towards teaching, sophisticated treatment, and research. The fact that three medical schools will soon have their own teaching hospitals, however, may be an indication that this trend will be checked.

The purpose of this chapter is to outline the role of the general hospitals in the health services industry. What are the functions of hospitals, and how do these institutions fit into the present health system? Certainly, it is no longer possible to conceive of the hospital simply as a place where the critically ill receive treatment, any more than it is to think of it as the custodial institution for the care of the indigent sick which the term "hospital" once denoted. The modern hospital provides a wide range of treatment services to inpatients and outpatients. It may be involved in preventing illness and in rehabilitation as well as in providing diagnostic and other medical services to the community. But even a rehearsal of these diversified services fails to convey the full complexity of the hospital's role in the health industry. The community general hospital has become a multi-functional institution, involved not only in the provision

of various types of patient care but in the production and dissemination of health science and skills, and in the regulation of health personnel. It is an educational and research centre and an organization of skilled personnel as much as it is a complex of medical facilities. Since it both provides health care and conditions the education and regulation of many groups of health personnel, the general hospital constitutes an appropriate point of entry into our description of these groups in this volume.

The role of the hospital in the regulation of the education and practice of health personnel in the province is two-fold. In the first place, the hospitals themselves are regulated by a number of external agencies, notably the provincial government. Given the centrality of the hospital in the health industry, the regulation of hospitals provides the provincial government with an important means of discharging its constitutional responsibility for health. In the second place, the hospital itself is involved in the education and regulation of most health personnel. In this chapter we will be concerned first with the control of health care and personnel exercised by external agencies through the medium of the hospital, and will then turn to a consideration of the hospital's internal functions of patient care, research, education and regulation.

Regulation of the Hospital System

The principal sources of external control over hospitals and the work done through them are the provincial government, which is constitutionally responsible for establishing and maintaining hospitals; the Ontario Hospital Insurance Commission, through which most hospitals are financed and which administers the Public Hospitals Act and the Private Hospitals Act; and the several agencies which establish quality standards by "accrediting" hospitals. Each of these external influences will be examined in turn.

Provincial and Municipal Governments

The British North America Act assigns to the provinces responsibility for the "establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals".⁷ However, the establishment of general public hospitals did not become an important provincial function in Canada; most of the initiative to establish hospitals of this kind came from urban and rural municipalities, religious organizations, and private individuals or associations.

Direct provincial sponsorship of hospitals in Ontario, as in the other provinces, has been confined mainly to the provision of long-term care institutions, notably mental hospitals and tuberculosis sanatoria. These are usually operated under the direct control of the provincial Department of Health. The others, including the municipal hospitals, have been subject to various forms of provincial government control.

⁷S. 92, subs. 7.

During the 1930's provincial involvement in the operation of hospitals greatly increased as a consequence of the inability of municipalities and other local bodies to finance the operation of facilities they had established or supported. Provincial assistance brought with it more detailed provincial supervision and advice on the planning, construction and operation of hospitals in the province.⁸

Responsibility for financing the capital costs of building and equipping hospitals in the province has been shared between the provincial government and local hospital boards. Beginning in June 1966, the provincial share of such costs was increased to a maximum of two-thirds of the total. The local boards are responsible for providing the necessary land and the remaining one-third of the construction and equipment costs. The provincial government also takes responsibility for the costs of constructing new schools of nursing and other hospital personnel training facilities.

When the federal Hospital Insurance and Diagnostic Services Act⁹ was passed in 1957, it made provision for the federal government to negotiate agreements with each province to share the costs of hospital insurance programs, which would be administered by the provinces.

When Ontario joined this plan in 1959, it entrusted the administration of it to a separate commission, the Ontario Hospital Services Commission (OHSC), rather than rely upon the existing departmental government structure. The responsibilities of the Commission were to include the development throughout the province of "a balanced and integrated system of hospitals and related health facilities", the approval of the establishment of new and additional hospitals and related health facilities and the administration and enforcement of the Public Hospitals Act, the Private Hospitals Act, and the regulations made under each of them.¹⁰

The Ontario Hospital Services Commission

A highly centralized form of administrative control is exercised over the hospitals of Ontario by the OHSC. The Commission possesses the "power of the purse" by virtue of its responsibility for administering the federal-provincial hospital care insurance program and for allocating construction and maintenance subsidies among hospitals.

Administering the insurance program involves the Commission in the budgetary process of the hospitals. The Commission determines the "allowable costs" — that is, the amount which it will pay to the hospital to subsidize the provision of inpatient services at the standard ward level, usually expressed summarily as "costs per patient day". The determination of these figures involves the Commission in the setting of comparative standards of hospital operating efficiency,

⁸J. E. F. Hastings, *Organized Community Health Services*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 7.

⁹Statutes of Canada, 5-6, Eliz. II, c. 28.

¹⁰Ontario Hospital Services Commission (OHSC), 1966 *Annual Report*, pp. 1-2.

including rates of remuneration for professional and non-professional staff and costs of laundry, food, drugs and surgical supplies based upon local market factors. The use of computer techniques has greatly facilitated the determination of these standards. Considerations of efficiency, however, are not the sole components of the budgetary formulae. The Commission maintains that its standards are flexible, and that the demonstration of a high quality of patient care can justify an allowable cost in excess of the standard.

In the case of public hospitals, an annual budget is prepared by the administrative staff of the individual hospital in accordance with the OHSC guidelines and submitted to the Commission, through one of its financial representatives, for review and approval. Budgets of private hospitals and nursing homes approved for chronic care are not reviewed in detail; rather, these institutions are subsidized on the basis of an annual contract. The amount paid to private hospitals is generally based on the per diem rate for public hospitals in the area. Nursing homes are paid at a flat rate which is uniform across the province.

The activities of the OHSC extend far beyond control of hospital budgets and the administration of hospital insurance. Its unique position as the possessor of centralized data concerning hospitals in the province has made it an important locus of research and planning for the provision of hospital services in the province. Indeed, charged as it is with the allocation of grants of hospital construction and maintenance, the Commission plays the central role in the hospital planning process in the province. It also diffuses the products of its research to individual hospitals through its visiting consultant services. In accordance with the above responsibilities, the Commission possesses the ultimate statutory authority over the provision of hospital services; it is charged with the enforcement of the Public Hospitals Act, the Private Hospitals Act, and the regulations thereunder.

The OHSC is also responsible for establishing and maintaining training institutes and centres for hospital workers and related personnel. Thus the Commission has a part to play in helping hospitals meet their labour requirements. There may be reason to fear that such arrangements might lead to these training programs being too greatly influenced by considerations of manpower supply at the expense of the quality of education made available to these categories of workers. Problems of this kind have arisen in connection with programs of nursing education conducted in schools financed through hospital budgets.¹¹ Although the situation with other types of hospital workers such as orderlies, technicians and other paramedical personnel is different, the advisability of entrusting their education to an agency such as the OHSC, which is necessarily "service" oriented, will be considered further in subsequent chapters on the various health disciplines.

¹¹See pp. 22-24.

The Ontario Hospital Association

Several other organizations, while possessing no statutory authority over hospitals, exercise considerable standardizing influence. Foremost among these is the Ontario Hospital Association (OHA). Membership in the Association is entirely voluntary, but its 250 members include all public general and special hospitals in the province, as well as sanatoria, certain provincial mental hospitals, and a few private hospitals. Seventy nursing homes have associate member status. The Association's functions are similar to those performed by most voluntary professional associations. It performs a general representative function on behalf of its membership vis-à-vis government and the public, maintaining formal and informal liaison with government agencies and professional groups, and operating public relations and recruitment programs. It provides consultative services, among which is the publication of a set of prototype by-laws which have had considerable influence in encouraging some uniformity among hospitals in the province. Through its functional subdivisions or Sections, the Association provides a forum for continuing education and exchange of information for various groups of hospital personnel. In addition, the Association administers a voluntary "prepaid" plan of hospital insurance (Blue Cross Plan for Hospital Care), offering benefits beyond those covered in the scheme administered by the OHSC. The Association has regional, as well as functional, subdivisions in the form of District Councils whose purpose is to foster closer ties between neighbouring hospitals and a cooperative approach to common needs.¹² At its central headquarters, it maintains a computer facility. Most computer time is now devoted to OHA administrative matters and "hospital work studies" aimed at increasing efficiency of hospital operation, but the Association plans to allocate some computer time with related programming and advisory service to member hospitals.

Accreditation

A number of agencies, each with varying objectives, are involved in the accrediting of hospitals. Accreditation for *patient care* is carried out by the Canadian Council on Hospital Accreditation (CCHA), an independent, non-profit corporation founded in 1958 by the Canadian Hospitals Association, the Canadian Medical Association, L'Association des Médecins de Langue Française du Canada, and the Royal College of Physicians and Surgeons of Canada. Although accreditation is entirely voluntary, most major hospitals in Canada have sought and achieved accreditation by the Council. The figures for Ontario are given in Table 7.1. Accreditation standards fall into five main categories: those concerning physical plant, medical staff organization, nursing services, hospital government and administration, and "essential services". In general hospitals the latter category includes emergency, laboratory, medical library, medical records, pharmacy and radiology.

¹²Ontario Hospital Association, *Directory of Services and Personnel*, p. 10.

In 1968 the College of Physicians and Surgeons of Ontario and the OHA began a continuing program of assessment of hospitals in Ontario with 200 beds or less. Visiting teams composed of three physicians and one hospital administrator report to a joint Review Committee of the College and the OHA concerning "medical and related services and the degree of compliance of the medical staff with the statutory provisions of the Public Hospitals Act and Regulation 523 under this Act, respecting hospital management and the medical staff by-laws of the hospital . . . (and) the general administrative affairs of the hospital".¹³ The objectives of the Committee are to make recommendations to each hospital visited concerning the improvement of the quality of medical care provided and in general to assemble a fund of information concerning smaller hospitals: "their relationship to the community, intraprofessional relations, and the adequacy of personnel and facilities."¹⁴

TABLE 7.1

Hospitals in Ontario Accredited by the Canadian Council on Hospital Accreditation as of December 1966¹

Number of beds	General hospitals			Long-term care hospitals (tuberculosis, chronic and convalescent)			Grand total
	Accredited	Not accredited	Total	Accredited	Not accredited	Total	
Up to 99 beds	22	68	90	5	6	11	101
100-299	44	15	59	9	12	21	80
300-599	29	—	29	3	1	4	33
600 beds and over	14	—	14	1	1	2	16
	109	83	192	18	20	38	230
Total accredited 127				Total not accredited 103			

¹Omitting mental hospitals, new hospitals not yet in operation or not in operation a full year, and hospitals under fifteen beds.

SOURCE: Evidence submitted by the Canadian Council on Hospital Accreditation. Reported in J. W. Grove, *Organized Medicine in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, Table 10, p. 200.

Quite apart from the above general accreditation and assessment procedures are a number of programs with more specific objectives. For example, the Ontario Medical Association Committee on Mortality Associated with Operative Procedures, reviews:

- (i) All fatalities occurring within twenty-four hours of induction of anaesthesia, general or local;
- (ii) All fatalities involving patients not recovering consciousness post-operatively;

¹³Report of the College of Physicians and Surgeons of Ontario, January 1969, p. 4.

¹⁴*Ibid.*

- (iii) Accidental happenings (cardiac arrest, fires, explosions, etc.) not necessarily resulting in fatality but from which useful information might be forthcoming.¹⁵

The Committee exercises no disciplinary power; its role is investigatory and instructional.

Programs of medical education in hospitals are the subjects of further accreditation programs. The educational facilities of university-affiliated teaching hospitals for undergraduates are accredited through their affiliation with the medical schools, by the Joint Accreditation Council of the American Medical Association's Committee on Medical Education and the Association of American Medical Colleges, with representatives from the Association of Canadian Medical Colleges. Postgraduate programs involve still other agencies. In order to be acceptable to the College of Physicians and Surgeons of Ontario, internship programs must be accredited by the Committee on Internship Programs of the Canadian Medical Association. Residency programs are accredited by the Royal College of Physicians and Surgeons of Canada. Accreditation of a hospital for patient care by the Canadian Council of Hospital Accreditation is nominally a condition of accreditation of its internship and residency programs, but at least one major teaching hospital is currently on the Provisionally Accredited list of the Canadian Council without being in danger of losing its internship and residency accreditations.

Hospital Functions

Patient Care Programs

Caring for the sick has been the traditional primary function of hospitals. Until late in the nineteenth century, this meant providing shelter and a measure of comfort for those of the sick who were unable to obtain such care outside the institution. The hospital consequently grew up with a charitable, benevolent character, oriented towards the poor who, upon successful appeal to the religious or lay authorities responsible for operating the institution, could hope to avail themselves of its help in time of distress. This help probably seldom extended to effective treatment of the patient's illness.

With the progress of medical science, the possibility of effectively treating many illnesses improved. Members of the community who had both the will and the means to seek medical care were able to do so. The extent to which such medical care was available to the inmates of hospitals depended upon the extent to which medical practitioners were able and willing to contribute their services to them. Apart from humanitarian reasons, one motive for physicians' doing so arose from their needs for medical teaching. The hospitals could provide a supply of patients readily available for teaching purposes in return for whatever treatment services could be rendered to them. As long as the hospital remained primarily

¹⁵J. W. Grove, *Organized Medicine in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, pp. 201-202.

a hostel for indigents, there was no necessary connection between the provision of medical care and hospital care. The physician was unlikely to remove his patient from his home to the hospital unless the patient had no home or private place of shelter and care.

During the late nineteenth century in Canada and in those countries by whose practices we were most influenced — the United Kingdom and the United States — the nature of hospitals changed radically. Many of these institutions began to provide facilities useful for the active treatment of illness as well as for the mere support of the sick. As surgical procedures developed, it became necessary for physicians to have operating room facilities of a kind which they could not often maintain independently. Hospitals provided operating rooms, nurses and the ancillary staff required to run them. Surgery became a hospital-based medical service and, at the discretion of the hospital's administration, the privilege of making use of these facilities and of having the patients involved lodged and cared for in the institution was extended to qualified physicians in the community. In the case of the community-supported "voluntary" hospitals in Canada and the United States, physicians were generally expected to provide some medical care to the hospital's indigent patients in return for such privileges.

During this century, the number and variety of treatment facilities available in hospitals have increased steadily. Developments in obstetrics, for example, have created a recognition of the need for aseptic delivery rooms. The practice of paediatrics requires incubators and other specialized treatment facilities. As nursing care evolved from an unskilled "housekeeping" function into a skilled occupation involving the treatment of illness as well as simply caring for the sick, hospitals became the principal places where such services were to be obtained. More specialized types of treatment services, such as therapeutic radiology and physiotherapy, have also been added to the list of facilities and services made available to physicians and their patients by the hospitals. The point has been reached where in many modern hospitals only about one-third of the space in the institution is used to accommodate patients. The other two-thirds is used mainly to house equipment and staff.¹⁶

Even more dramatic has been the provision by hospitals of increasingly elaborate diagnostic facilities and services. Laboratory and radiology departments have become both numerous and complex. The array of elaborate and expensive electronic, radiological and biochemical instruments and procedures used in modern medicine are beyond the financial and technical resources available to the physician who must utilize them. Although independent laboratories and radiological facilities are available outside hospitals in some larger centres, such facilities are increasingly associated with the hospital.

¹⁶H. M. Somers and A. R. Somers, *Doctors, Patients, and Health Insurance*, Brookings Institution, Washington, D.C., 1961, p. 66.

Thus hospitals today are involved in providing an elaborate range of diagnostic and curative services to the community. In Ontario in 1966, public general hospitals provided over fifty-six million units of laboratory services and more than two and one-half million radiological examinations.¹⁷

Within a surprisingly short period of time the hospital has been transformed from a place where the sick poor could seek refuge until spontaneously recovered or, more likely, freed from their suffering by death, into a place where rich and poor alike — the relevance of the distinction becoming more and more blurred as a result of insurance and prepayment schemes — go to find out what is wrong with them and to have it treated.

Most hospital care today consequently is not a simple custodial function, but an extremely complex service requiring the coordination of an elaborate physical plant with the work of a great variety of professional and skilled employees and persons otherwise associated with the institution. It has become difficult to conceive of modern medical care without thinking of *hospital* care. Much of the modern practice of medicine is conducted in hospitals. Moreover, it is increasingly difficult to define hospital care solely in terms of the services rendered to patients in hospitals. Many of the services offered by modern hospitals are rendered to outpatients and to members of the community at large. This is attested to by the extraordinary rise in the use of hospital emergency rooms as places for the general practice of medicine.

Although the provision of inpatient care remains the hospital's essential function, some hospitals seem to be becoming relatively less concerned with the provision of such care for the acutely ill and increasingly involved in other forms of patient care in the community. Ambulatory care, self care, continuing care, and various forms of home care services are frequently being organized and made available by hospitals.

The nature and extent of these various types of patient care services now being provided by hospitals in Ontario are described briefly in the following sections.

Inpatient Services

Despite the expansion of hospital functions in recent decades, most general hospitals in Ontario today are mainly, some almost entirely, concerned with the treatment of short-term acute illnesses of inpatients. The average length of stay in Ontario public and private hospitals providing active treatment is just over ten days in duration. In 1965 almost ten and one-half million days of such active treatment were provided in these hospitals. Long-term care of the chronically ill amounted to something over two million patient days in 1965 and convalescent care to approximately 300,000 patient days in the same year.¹⁸ It might be expected that rapid improvements in medical science would have caused a trend towards reduced active treatment days in our hospitals; but it appears that gains

¹⁷OHSC, *Annual Report (Statistical Supplement)*, 1966, p. xv.

¹⁸OHSC, *Annual Report (Statistical Supplement)*, 1965.

in prevention of disease and in reduced time required to effect cures have been offset by the possibilities of treating previously untreatable diseases, by the increased use of active treatment beds for diagnosis and observation, and by the prolongation of life for more and more people into the older age groups who require more frequent and extended treatment.

The services normally provided to inpatients include accommodation and meals; nursing services; laboratory, radiological and other diagnostic procedures, many of which are rendered by hospital staff; physiotherapy; and what is generally referred to as "use of the operating room". The latter implies, of course, that professional services such as surgery, anaesthesia and obstetrics are actually provided by the patient's "own" physician independently of the hospital itself. In fact, a wide range of ancillary medical services associated with surgical and other procedures are provided by physicians, nurses, and technicians of various kinds who are not so much independent practitioners as they are hospital employees or people who work full time in the hospital. This is particularly true of teaching hospitals where many of the professional staff responsible for providing patient care may be on salary or have some form of contractual arrangement with the hospital. Full-time chiefs of service, radiologists and pathologists are likely to receive their income or some very large part of it by virtue of their position in the hospital. The 1,500 internes and residents in hospitals in Ontario are paid from hospital revenues.¹⁹ Furthermore, those with teaching duties usually receive a salary paid by a medical school with which the hospital is affiliated. This creates a number of financial, administrative and legal problems which will be alluded to later in this chapter and again in Chapter 27. Here the point is relevant as an indicator of how the role of the hospital is changing from being the "physician's workshop" to becoming an active supplier of medical care in its own right.

Apart from the great increase in the quality and different types of care provided by hospitals to the patients in them, the other revolutionary change of recent years has been in the method of financing this treatment. Reference has already been made to the importance attached to the hospitals as places for the teaching of medicine, and the research that must accompany it, once medicine became an empirically based scientific profession. Patients who could not otherwise pay for their keep had some value to the teaching hospital and its physicians as "clinical material", receiving free care and treatment in return for being available for such purposes. Those who could were, of course, expected to pay for their care. While the distinction between the paying patient and the non-paying patient is not one which physicians or hospital administrators are much inclined to comment upon, except to deny its relevance in relation to the quality of care provided, the disappearance of the distinction as a result of hospital insurance programs has created a new problem for the teaching hospitals. An examination of the standard ward revenues of 225 hospitals in Ontario for the year 1966 shows that over 95 per

¹⁹See Chapter 6, Table 6.9.

cent of them were in the form of payments received through the Ontario Hospital Insurance Plan. The balance was made up of payments from the federal government and the Workmen's Compensation Board; payments from non-residents and from Ontario residents covered by plans other than OHSC; and small amounts in the form of fees from uninsured patients. In reporting the development of a similar situation in the United States, the American Medical Association Citizens Committee on Graduate Medical Education in 1966²⁰ commented that the "... decreasing number of free or ward patients constitutes a widely recognized difficulty for graduate medical education".

Further implications of this and other consequences stemming from the change in the method of paying for hospital services are considered elsewhere in this Report.²¹ Some of these are gross and self-evident. The effect on hospital utilization would be an example: the physician need not consider the patient's ability to finance a stay in the hospital, given such arrangements. Thus there may be a tendency to overutilize hospital facilities and to prolong the patient's stay. The high and rising costs of hospital care make any possible overutilization of real concern to the taxpayer. Other consequences may be more subtle. The patient who sees hospital care as something he has a right to and has paid for is likely to have a rather different attitude towards the institution and the kind of care and treatment it provides him with than might otherwise be the case.

Ambulatory Services

Once hospitals had evolved into places for treating and not merely housing the sick, it naturally followed that hospitals would come to be identified as places where medical help could be obtained directly. In a system of predominantly private medical practice, this has created a number of problems. If medicine could be practised only by private, licensed physicians, the hospital itself could not provide the treatment required by patients who presented themselves for help. However, if licensed physicians associated with the hospital would make themselves available to treat such patients, suitable services could be provided. Out-patient clinics in England and the United States in the nineteenth century came to be associated with the voluntary treatment of charity cases by private physicians who volunteered their time without charge. The poor who lacked private physicians or were unable to afford private treatment thus could obtain medical services at the outpatient clinic of a hospital. As in the case of indigent inpatients, there were several reasons why the hospitals and the physicians concerned should have provided such services without charge. For hospitals operated by religious bodies and by municipal governments, the outpatient clinic was an important service to the community. Local doctors associated with the hospital could be expected to contribute some of their time to staffing outpatient clinics in return for the privi-

²⁰The *Graduate Education of Physicians*, Report of the Citizens Committee on Graduate Medical Education, Commissioned by the American Medical Association, Chicago, 1966, p. 75.

²¹See Chapter 27.

lege of admitting their own private patients to the hospital. In the case of the teaching hospitals, the outpatient services provided an important source of clinical teaching material. Furthermore, the junior staff of internes and residents could provide much of the labour required in return for educational experience and, perhaps, some very modest living accommodation and meals. Given these arrangements, those members of the community who had no personal physician could go to the hospital as an alternative means of establishing contact with the health delivery system.

Other types of outpatient services provided by hospitals may include diagnostic and some types of treatment services to patients who do not require admission to the hospital. A range of related services, including home care, physiotherapy and continuing care, may also be included in the outpatient services of some hospitals. These latter services will be considered separately below.

Since the outpatient services of hospitals bring these institutions directly into the role of providing medical care to the community, a problem may be created of reconciling the hospital with the system of medical care provided by private physicians. The latter have had some reservations about the development of outpatient services in hospitals, particularly those of the organized outpatient clinic kind. These were not considered to constitute a serious problem as long as they confined their work to the treatment of indigents. The medical profession in the United Kingdom, in the United States, and in Canada, however, has tended to view this kind of medicine as "inferior" to that practised by the private personal physician. One reason for this attitude has been that the patient attending an outpatient clinic received treatment of a routine, impersonal kind, from physicians who had no personal direct knowledge of him. Patients, too, have had reason to shun the outpatient clinics if they could. Visits to such a clinic, as one experienced American physician has written, are marked by "the long hard bench, the four-hour wait, multiple referrals, incredible discontinuity of care, and various other indignities suffered in an anti-social and decadent environment".²² While this statement may be exaggerated, it does reflect certain common complaints often voiced by patients.

The advent of mass hospital insurance coverage and medical care schemes, along with general improvements in income levels, has also influenced the use made of organized outpatient clinics. Despite the growing role of the hospital in the community health service, the organized outpatient clinics of the traditional kind have not become as popular in North America as might have been expected. One reason for this in Canada has been that although the Federal Hospital Insurance and Diagnostic Act authorizes the federal government to contribute towards the cost of providing all the services available to inpatients, when these are provided to outpatients, provincial governments have been free to choose whether or

²²Dr. John Knowles, General Director of the Massachusetts General Hospital, as quoted in H. M. and A. R. Somers, *Medicare and the Hospitals*, Brookings Institution, Washington, D.C., 1967, p. 73.

not to make such services insurable under their provincial plans. In Ontario, until recently, the Ontario Hospital Services Plan provided coverage only for a limited range of such services when they were administered on an outpatient basis. In 1968 these benefits were expanded to cover virtually all those services not covered by the then existing Ontario Medical Services Insurance Plan. Radiotherapy for the treatment of cancer, occupational therapy, physiotherapy and speech therapy also may be covered when provided in specified hospitals.²³

The contemporary outpatient department is a type of organizational unit still confined for the most part to large urban hospitals.²⁴ The department, as described in the Ontario Hospital Association's prototype by-laws, may consist of both general and specialty clinics. Specialty clinics (such as surgery, ophthalmology, otolaryngology and paediatrics) are organized, staffed and conducted by the relevant service or department of the hospital. Either the department of general practice, where this division exists, or the hospital administration may be charged with the staffing and operation of the general medical clinic. In either case, it is usually staffed by house and associate staff, working under the formal direction of a rota of active staff members. In smaller rural hospitals, the outpatient department, if it exists at all, is composed entirely of the general medical clinic. Specialty clinics are found only in large, usually urban hospitals, where both a departmentalized structure and a sufficient demand for the specialized service warrant their existence. One aspect of the changing role of the outpatient department is the increasing number of referrals by private medical practitioners to these clinics.

Another type of outpatient unit, which may or may not be operated under the aegis of the outpatient department, is the Family Practice Unit. In its most fully developed form this unit is, in effect, a hospital-based group practice, staffed by full-time general practitioners who operate their practices from the hospital, aided by ancillary personnel and backed by the hospital's specialist staff. As of 1969, the only hospitals in Ontario to have established such units were Henderson General Hospital in Hamilton, affiliated with McMaster University, and St. Joseph's Hospital in London, affiliated with the University of Western Ontario.²⁵ At Sunnybrook Hospital, the teaching hospital owned and operated by the University of Toronto, such a plan is in its early stages. A number of other Ontario hospitals have established so-called Family Practice Units, but these are currently sections of the outpatient department staffed for the most part by part-time general practitioners (some full-time appointments have been made). All Family Practice

²³*Annual Report of the Minister of National Health and Welfare on the Operation of Agreements with the Provinces under the Hospital Insurance and Diagnostic Services Act*, fiscal year ending May 31, 1967, p. 6.

²⁴Out of a sample of ninety-five active treatment hospitals replying to a 1967 College of Family Practice questionnaire, thirteen had established outpatient departments. Of these, seven were teaching hospitals; two were in rural areas; and only three had less than 200 beds.

²⁵See Chapter 26 for a discussion of the St. Joseph's Hospital Family Medical Centre.

Units are affiliated with teaching hospitals, a fact which reflects the primacy among their functions of educational responsibilities: the exposure of the medical student to a high quality of general practice in his undergraduate years, and the training of undergraduates (and graduates in the McMaster and Western programs) in a redefined form of general practice.²⁶

Although the organized indigent type outpatient clinic has not become a major form of outpatient facility in today's hospitals, the same type of outpatient service under a different name is the so-called "emergency service". Statistics relating to outpatient services are notoriously difficult to collect and to interpret, but there is no doubt that the emergency services are one of the most rapidly growing functions of today's hospitals. Because these services are supposedly provided to persons suffering from sudden minor or major trauma requiring immediate treatment, this might seem to suggest a remarkable increase in such injuries and sudden afflictions. Happily, this is not the case; for it is generally agreed by those providing these services that they are being used by people who simply want medical attention and who choose to get it at the emergency department of the hospital rather than at a physician's private office, or have no other option readily available. We will consider the reasons for this trend towards increasing use of "emergency" services of the hospital and its implications in Chapter 27.

Psychiatric Services

Although some early general hospitals established in Canada provided refuge and care for both the physically and the mentally sick, during the nineteenth century the provision of large central mental hospitals to care for the latter became the established practice in this country.²⁷ "General" hospitals subsequently came to be limited to caring for those with physical infirmities. In the last few decades, however, there has been a strong movement to provide facilities in general hospitals for the care and treatment of short and intermediate term psychiatric patients. This has reached the point where it has been claimed that "... today any large hospital without a psychiatric service is not fulfilling its proper functions".²⁸ Thus in 1966, of eighteen Group A general hospitals in Ontario, eleven had psychiatric beds, as did thirteen of the thirty-five Group B and Group C hospitals of over 250 rated bed capacity size.²⁹ This type of mental treatment facility has been expanded in Ontario, along with the development of community psychiatric hospitals, as an alternative to the large centralized mental

²⁶See Chapter 30 for further discussion.

²⁷A. Richman, *Psychiatric Care in Canada: Extent and Results*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1966, p. 53.

²⁸C. B. Farrar, "The Early Days of Treatment of Mental Patients in Canada", *CAMSI Journal*, February 1962, pp. 13-15, cited in *ibid.*, p. 53.

²⁹OHSC, *Annual Report (Statistical Supplement)* 1966, Table I, pp. 3-4.

hospitals (the Ontario Hospitals) previously relied upon. This has been in keeping with the recommendations of the 1964 Royal Commission on Health Services. As reported in Charles Hanly's research study for the Committee, "... the trend in recent years has been to treat mentally ill patients requiring short-term or intermediate care in a general hospital setting".³⁰ Whether or not this is the most suitable way of providing this treatment is considered elsewhere in our Report.³¹

According to the data presented in Chapter 28, the percentage of general hospital beds reserved for psychiatric cases has increased in the last few years. Moreover, the increase in the amount of psychiatric services being provided in psychiatric units of general hospitals relative to mental hospitals is probably understated by these data. Because they provide mainly short-term treatment to patients with a favourable prognosis, each bed represents treatment for a large number of patients in a year compared to institutions handling longer term cases.³²

These units also provide a large quantity of outpatient service. Indeed the amount of outpatient work appears to be expanding relative to the inpatient services, partly as a consequence of the changing approach to the treatment of mental illness described in Chapter 28. Here this is of interest as one more force working to alter the role of the general hospital in the community.

Although lack of useful data relating to psychiatric outpatient services makes it impossible to describe the nature or quantity of these services with any precision, the operation of psychiatric and "community mental hygiene" clinics as part of the hospital's outpatient services is one of the important factors transforming the hospital into a community health care centre.

In its purest form, the "day hospital" for psychiatric patients has influenced the development of other types of hospital-based treatment facilities for geriatric, physically handicapped, and other types of patients who do not require admission. The concept of the "day hospital" was promoted in North America in the mid-1940's by the Allen Memorial Institute, a psychiatric teaching hospital in Montreal. Although the idea of developing such specialized facilities has not been widely accepted, something of this approach has been embodied in a number of large general hospitals which admit psychiatric patients for treatment during the day, sending them home at night.³³ This expansion of the hospital's role in the provision of health services to the community may also be seen in several other innovations described below.

³⁰OHSC, Annual Report, 1965, cited in C. Hanly, *Mental Health in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 262.

³¹See Chapter 28.

³²See Canada, Department of National Health and Welfare, *Hospital Care in Canada: Recent Trends and Developments*, Ottawa, 1960, p. 24.

³³The general practice is described in L. G. Jackson, *Hospital and Community*, Macmillan, New York, 1964, p. 689.

*Progressive Patient Care: Self Care,
Extended Care and Rehabilitation Services*

Although they are as yet experimental and not widely applied in existing hospitals in Ontario, or anywhere else in North America, several new approaches to patient care have been developed which may be of great future significance.

Hospitals under imaginative leadership have developed psychiatric units and moved toward "progressive patient care", although they seem slow to progress on from intensive care units to self care, extended care, and rehabilitation facilities.³⁴

The central concept underlying these developments may be variously identified, but perhaps the most common term in use is "progressive patient care". "The central theme is the systematic classification and segregation of patients according to degree of illness and need for care rather than according to specific diagnoses or economic status — the traditional basis of classification."³⁵ As outlined by the United States Public Health Service, this classification is as follows:

- 1) Intensive care.
- 2) Intermediate care.
- 3) Self care.
- 4) Long-term care.
- 5) Organized home care.

The first four of these classes of care are provided within the hospital itself. Intensive care units, now established in several larger hospitals in Ontario, are intended to provide constant supervision of critically ill patients, with immediate access to lifesaving equipment. The intermediate care is similar to that normally provided in most general hospital wards for patients who may be partially ambulatory. Self care units, a logical but so far little accepted corollary of the intensive and intermediate types of care, are designed for patients who can care for themselves but are required to be in hospital for purposes of diagnosis or convalescence. Long-term care is for patients who require nursing and medical services over prolonged periods of time.

One important implication of this approach is that once hospital patients are separated into these four classes and hospital facilities and services reorganized accordingly, it is possible that self care, and perhaps long-term care, could be more effectively and economically provided in facilities physically and organizationally different from the typical general hospitals as we know them today. "Motel"-like facilities for self-care patients and for outpatients requiring overnight accommodation in conjunction with diagnostic procedures, while still experimental, are suggestive of what may be an important future trend in the evolution of hospitals.

³⁴F. D. Mott, "Patterns of Medical Care", School of Hygiene, University of Toronto, paper presented at University of Michigan, January 17, 1967, mimeo, p. 4.

³⁵H. M. and A. R. Somers, *Doctors, Patients, and Health Insurance*, op. cit., pp. 72-73.

The fifth part of the progressive patient care approach, organized home care, is not necessarily a hospital-based function, nor is it a new approach to the care and treatment of patients who do not require the special facilities of the hospital. Nevertheless, "the idea of organized home care originated from attempts to extend some of the services normally provided within the walls of the hospital into the patient's home."³⁶ The visiting nursing organizations, such as the Victorian Order of Nurses for Canada and various voluntary community service groups, have long provided some services of this type in Ontario and other parts of Canada. But it is only in the years since World War II that attempts have been made in some communities to organize the activities of the various agencies and professionals involved in the provision of these services. Some of these have used the hospital as the coordinating agency. Whether or not the hospital is the appropriate agency to assume such responsibilities is a controversial question which will be considered in Chapter 24.

A closely related development is the involvement of hospitals in the practice of "rehabilitation medicine", which also involves the hospital in extramural responsibilities. "Modern rehabilitation medicine is concerned with a group of patients with stabilized and permanent functional impairment beyond the effectiveness of preventive or curative medicine and surgery."³⁷ The rehabilitation of persons suffering mental or physical handicaps has become an important medical and social function, especially during the years since the end of World War II.³⁸

Like the home care programs, rehabilitation services are part of a large and, for the most part, weakly coordinated group of activities and programs. The role of the hospital in providing and coordinating these services is as yet ill-defined. Even so, the role of hospitals in this field appears to be growing. In 1964, a study for the Royal Commission on Health Services reported:

. . . In more and more urban hospitals, physiotherapy is available to patients. In a few large urban hospitals, usually teaching hospitals, extensive in-patient and, in some cases, out-patient rehabilitation services are provided. These may include social counselling, day care, and home services. In-hospital services in Toronto and Peterborough are developing rapidly . . .³⁹

In the rural and smaller urban hospitals in Ontario, however, the development of such facilities appears to be impractical. Because of problems of staffing and organization, it appears that much of the future development of rehabilitation and other programs with which it must be coordinated will be organized on a broader administrative and a geographical basis.

³⁶R. Kohn, *Emerging Patterns of Health Care*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1966, p. 61.

³⁷G. Gingras and B. Primeau, "Paramedical Personnel in Rehabilitation Medicine", Canadian Medical Association Conference Manuscripts, *Medical Care Insurance and Medical Manpower*, Montreal, June 19-23, 1967, p. 214.

³⁸R. Kohn, *op. cit.*, p. 55.

³⁹J. E. F. Hastings, *op. cit.*, p. 55.

Other Hospital Functions

The modern hospital is much more than the locus for the provision of the treatment services just described; it also plays a crucial role, through its educational, research and regulatory functions, in the generation of medical knowledge, in the production of medical and paramedical personnel, and in the conditioning of their interrelationships.

Medical Education

The predominance of the hospital in the provision of medical education, both formal and informal, has developed apace with its predominance in the health care delivery system as a whole. As hospitals increasingly became centres for diagnosis and therapy rather than merely custodial institutions for the incurable, they became convenient locations for the provisions of the clinical aspects of the physician's training. As expanding technology made possible forms of diagnosis and treatment which could be performed only with the complex equipment and numbers of personnel available in the hospital context, the hospital became not only a convenient but an essential location of the doctor's initial training and continuing education.

At the turn of the twentieth century, the incorporation of the hospital into the program of medical education in North America drew impetus from two important sources. The first was the influence of Sir William Osler, the Canadian-born physician whose exemplary use of clinical teaching by the hospital bedside at Johns Hopkins medical school from 1897-1912 did much to popularize this method throughout the continent. The second was the highly influential Flexner Report, submitted to its sponsor, the Carnegie Foundation, in 1910. Its condemnation of the state of medical education in the United States and Canada was taken seriously by the profession and its proposals for reform were largely implemented over the next twenty years.⁴⁰ The apprenticeship system and the numerous sub-standard proprietary schools (the infamous "diploma mills") virtually disappeared. Medical training became a field of university education, centred in the university teaching hospital. Until very recently, the last two years of the undergraduate professional program in medicine have been conducted largely in community general and allied special hospitals affiliated with the medical schools; at present, hospital instruction starts even earlier. The details of the affiliation relationship and the problems arising from it are discussed at considerable length in Chapter 24.

Internships and residencies. The provision of medical education is not as yet a function limited to university-affiliated teaching hospitals. The postgraduate phases of medical education — internships and residencies — traditionally have been provided independently of medical schools by individual hospitals. There

⁴⁰See Chapter 25 for a fuller discussion of the Flexner Report, its assessment of Ontario medical schools, and its implementation.

has been a growing trend, however, towards the restriction of internship and residency programs to teaching hospitals and to the growing involvement of the medical school in their control.

At present, internship programs are supervised immediately by the director of medical education or the medical director, who acts as an assistant to the administrator. More general supervision and direction is exercised by the Interne Committee of the hospital. The same personnel are responsible for the selection and appointment of internes. The informality of the process of selection and appointment of internes has led to charges of favouritism and to the establishment in 1966 of the Canadian Interne Placement Service, operated by a joint committee of the Canadian Association of Medical Students and Internes (CAMSI), the Canadian Medical Association and the CHA, with the objective of rationalizing and facilitating the placement process.

The junior interne is not a licensed physician, since the completion of a one-year junior internship to the satisfaction of the College is a condition of licensure in Ontario.⁴¹ Hence his practice is restricted to the hospital to which he is assigned, and certain limitations are placed upon his practice therein. The interne treats patients at all times under formal supervision of the member of the hospital medical staff who is attending each particular case in which the interne is involved. The *actual* supervision of the interne, especially in the emergency department, is often more formal than real. Registration of internes on the Educational Register of the College of Physicians and Surgeons has been mandatory since 1965, and ultimate disciplinary authority rests with this body.

The College of Physicians and Surgeons of Ontario has taken accreditation by the Committee on Internship Programs of the Canadian Medical Association as a sufficient condition of approval of Canadian internship programs. Recently the College itself has begun to make additional tours of inspection of CMA-approved internship programs in Ontario. All of the eighteen hospitals in Ontario approved for interne training are public general hospitals. Twelve are teaching hospitals, and account for the training of about three-quarters of the internes educated in the province.⁴²

The training of residents is less formal than that of internes. The residency program, usually of four or five years' duration, is made up of blocks of one year, each of which may be spent in a different hospital. The Royal College of Physicians and Surgeons of Canada, the body which sets the final examinations for fellowship and certification in the clinical specialties, approves hospitals for specialty training.⁴³ As of March 1966, forty-two hospitals in Ontario were approved for specialty training, although some of these were approved only for

⁴¹An additional year of *senior* internship may be elected after licensure.

⁴²The figure in 1966-1967 was 72.9 per cent; derived from a table in *CAMSI Journal*, September 1967.

⁴³Hospitals are approved for training in separate specialties, not for specialty training in general.

limited periods of training, while others had approval to provide the entire specialty program. At present, the Royal College requires as a precondition of sitting its examinations only the completion of a program of sufficient length in hospitals whose facilities and resources it has approved for specific periods of training. Selection, appointment and training of residents are effectively in the hands of the chief of the relevant hospital service. Although in some cases a post-graduate committee may be charged with these functions, their decisions usually rest upon prior approval of the hospital services. After 1970, however, the Royal College will require that the actual content and format of residency programs obtain its approval as well; and a precondition of its approval will be the provision of all specialty training within the context of an integrated program within university-affiliated institutions. In keeping a closer watch on the selection and training of residents at all stages of the program, the Royal College hopes to effect a reduction in the high failure rate of its examinations.

Informal aspects. Finally, it must be acknowledged that the hospital's role in medical education is not confined to its formal programs. The importance of association with his colleagues in daily hospital life and participation in the activities of the organized medical staff (as outlined below) for the maintenance and improvement of the physician's competence cannot be overstated. At the conclusion of a 1963 survey of general practitioners in Ontario and Nova Scotia, Dr. Kenneth Clute strongly emphasized the importance of this aspect of the hospital's educational role. He quotes a prominent British medical educator to the effect that "The lifelong maintenance of a high standard of informed, critical, and conscientious practice depends more than anything else on the avoidance of professional isolation",⁴⁴ and concludes, "This we regard as one of the strongest arguments against any system which would exclude a general practitioner from the work of a hospital and hence tend to isolate him."⁴⁵ The problem is most acute in the case of the general practitioner, but the relevance of the argument extends to all members of the profession. We shall have more to say concerning this crucial issue in the context of our discussions of hospital privileges in Chapters 8 and 27.

*Nursing and Paramedical Personnel*⁴⁶

The development of formal nursing education in the United States and Canada during the nineteenth century took place in the hospitals and under the influence of hospital authorities. (See Chapter 10.) The hospital-based school of nursing thus became the foundation of nursing education in this country and, until very recently, remained so. An important aspect of this function has been the willingness of hospitals to assume responsibility for organizing and providing nursing education in return for the services rendered by student nurses. For the student, this meant the availability of an inexpensive form of preparation for a career in

⁴⁴K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963, p. 461.

⁴⁵*Ibid.*, p. 462.

⁴⁶We use the term "paramedical" here, as throughout the Report, in a broad sense. See Chapter 1 for a discussion of this point.

nursing. For the hospital it meant a supply of inexpensive labour while the students were in training. Nevertheless, for reasons discussed in Chapter 10, the hospital-controlled nursing school has recently declined in popularity. This does not mean that hospitals no longer play an important part in nursing education: they do. As shown in Table 7.2, many hospital schools still operate in Ontario and turn out an important part of the supply of diploma nurses. Even where the school has moved out of the hospital, nursing students must still depend on the hospital for much of their practical and clinical education experience.

TABLE 7.2

Nursing Schools Operated by Public General Hospitals in Ontario, 1964-1968

Year	No. of hospital schools	Enrolment	No. of graduates
1964	—	7,678	2,307
1965	57	7,902	2,420
1966	55	8,059	2,292
1967	55	7,739	2,362
1968	55	7,343	2,603

SOURCE: OHSC, *Annual Report (Statistical Supplement)*, 1966, 1967, 1968, Table K, p. xvi.

General hospitals have also been the principal training ground for nursing assistants and many other paramedical groups educated through formal training programs.

There is no need to reiterate here the reasons for the hospital's traditional interest in the training of nurses and nursing assistants; for no matter how the roles of nurses and hospitals change, the nursing function remains an indispensable hospital service and nurses by far the largest group of hospital paramedical personnel. In some hospitals which provide mainly chronic and convalescent patient care, this nursing function is the institution's main reason for existing. But when we look at the active treatment hospitals, which contain some 80 per cent of the beds controlled by the Ontario Hospital Services Commission, we find that they also employ very large numbers of paramedical personnel, many of whom have little if any contact with patients. This reflects the many scientific and technological developments taking place in hospital medicine. Paramedical personnel include laboratory technicians, radiological technicians, medical record librarians, electroencephalograph technicians, electrocardiograph technicians, physiotherapists, occupational therapists, radio-isotope technicians, inhalation therapists, heart laboratory technicians, and assistants in clinical investigation units. While these occupations, many of which are of very recent origin, are not necessarily found only in hospitals, their work is so interrelated that it appears inevitable they will be found principally in a hospital or hospital-like institution. As Hall has remarked about these occupations, "In a very real sense the hospital generated them; now they are essential to its operation and survival."⁴⁷ Of course, this rich

⁴⁷O. Hall, *The Paramedical Occupations in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 2.

complement of paramedical personnel is not found in all hospitals. The smaller institutions in the province have few, while the large teaching hospitals employ all or almost all of the above groups.

The training of these skilled workers takes a variety of forms. Many, as shown in detail in Chapters 16, 17 and 18, receive only a rudimentary form of on-the-job training. Others obtain at least a part of their training in special institutions outside the hospitals. Formal training programs are offered in hospitals for the occupations listed in Table 7.3.

TABLE 7.3

Formal Training Programs in Public General Hospitals in Ontario for Other Paramedicals, 1968

Enrolment	No. of hospitals	Graduates
Nursing assistants	31	688
Radiological technicians	64	213
Laboratory technicians	58	259
Medical record librarians	3	28

SOURCE: OHSC, *Annual Report (Statistical Supplement)*, 1968, p. xvi.

Although it is too early, given the recent origin of many of the paramedical occupations, to say with any certainty what the trends in their education and training patterns are likely to be, if we were to follow the same models for these programs as those used in the United States, an increasing number of such occupations would turn to colleges and universities as the proper locale for their training. As we note in Chapter 18, training programs for certain types of paramedicals are quickly being established in Colleges of Applied Arts and Technology in Ontario.

Research

The entry of the hospital into the field of medical research has occurred for the most part in the last twenty years. Previously medical research was conducted almost exclusively in the universities by investigators trained in the basic and pre-clinical sciences. In the past two decades, however, the importance of *clinical* research has been increasingly recognized. The result has been the establishment of "clinical investigation units" in several university-affiliated teaching hospitals. This type of unit is defined by the Association of Canadian Medical Colleges as follows:

A Clinical Investigation Unit consists of two parts:

- (1) A separate area consisting of a designated number of beds with special kitchen dietetic and other facilities when appropriate.
- (2) Adequate laboratory space close to the Unit's bed space, containing basic equipment related to research work carried out.

The permanent personnel would consist of technical, dietetic, and essential nursing staff under the direction of a competent clinical investigator.⁴⁸

The development of automated techniques of laboratory testing is facilitating another form of hospital-based research: experimentation with large-scale computer analysis of test results in an attempt to devise more rapid and efficient diagnostic techniques. Such research is still at an embryonic stage in Canada, but programs in several American hospitals indicate its promise. The growth of medical research in hospitals in Ontario has been hampered by a lack of agreement concerning financial responsibility for these programs, an issue to which we shall return in the next volume.

Regulation

The management of an institution as complex and multi-functional as the modern hospital requires that its organizational structure be formalized, and that the activities and interactions of its personnel be regularized and controlled. The hospital formally employs a large number of professional and non-professional health workers, and grants yet other personnel access to its facilities subject to definite conditions. As more and more medical care comes to be provided in the hospital, the terms of employment or access laid down by the hospital increasingly assume the nature of informal licensing regulations. Indeed, these developments have led two eminent critics of the health industry in the United States to observe: "The hospital has become the most powerful standard setter or police agent of the medical profession today — one reason it has become so controversial."⁴⁹

This statement applies equally to a number of professional groups other than physicians. So influential has the hospital become in this respect that any attempt to examine the regulation of health professionals which neglected the hospital would be woefully incomplete. But to speak of "the hospital" here is a gross oversimplification. The complex systems of organization and authority through which health personnel are regulated in the hospital require much fuller explication.

Internal Organization

The administration of the provision of clinical care and the regulation of health personnel within the hospital are accomplished through two systems of authority: the "line" and the "staff" systems, in the parlance of administrative theory. The line system comprises the nursing, paramedical and non-professional personnel, organized hierarchically under the hospital administrator; the staff system comprises the medical staff. The theory from which the administrative organization and functions of the medical staff are derived views the staff as a group of independent equals individually responsible for the care of their patients and collectively responsible for the policing of the quality of care provided by their number

⁴⁸J. A. MacFarlane et al., *Medical Education in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1965, p. 145.

⁴⁹H. M. Somers and A. R. Somers, *Doctors, Patients, and Health Insurance*, *op. cit.*, p. 113.

within the confines of the hospital "workshop". The Board of Trustees entrusts to its administrative employees the operation and maintenance of this workshop. It permits physicians to use these facilities and delegates to the collective medical staff the authority to supervise the provision of clinical care. To exercise this authority, the medical staff organizes itself into a system of committees. However poorly this theory corresponds to the actual operation of the hospital,⁵⁰ it provides the perspective in which the formal aspects of hospital organization become intelligible.

The Board of Trustees

Both systems of authority — line and staff — culminate formally in the Board of Trustees (or Governors), with whom rests the ultimate control of the hospital. The composition of this body varies with each institution in accordance with the circumstances of its birth. In community general hospitals it is usually elected by members of the hospital corporation; members may be patrons of the hospital dues-paying members, appointees of community bodies, or honorary members. In other cases, trustees are popularly elected in city elections. In public hospitals owned by religious orders, the Board is appointed by the order but includes representatives of the community.⁵¹ Regulation 523 under the Public Hospitals Act charges the Board with responsibility for the hospital's compliance with the Act, the regulation, and the by-laws of the hospital.⁵²

The effective (as opposed to the formal) control exercised by the Board of Trustees varies widely among hospitals. Not surprisingly, the Ontario Medical Association maintains that effective control of the quality of medical care provided in the hospital should reside with the medical staff, while the Ontario Hospital Association (OHA) sees the Medical Advisory Committee literally as *advisers* to the Board of Trustees. The OHA, in fact, has expressed reservations concerning the statutory provision for the election of the Medical Advisory Committee by the medical staff (see below) lest this "have the effect of preventing a hospital board from having a voice in choosing its own advisors on medical matters".⁵³ Under Ontario law, some representation of the Medical Advisory Committee on the Board is compulsory in hospitals of over 100 beds. The by-laws of these hospitals must provide for the inclusion of the elected president and vice-president and one other member of the medical staff as full voting members of the Board.⁵⁴ It is felt that in smaller hospitals such a provision would enable these individual members of the medical staff, with their own vested interest, to exercise an undue influence vis-à-vis the medical staff as a whole, represented through the Medical Advisory Committee. It may be, indeed, that a size of 100 beds does not offer sufficient insurance against such a situation, and that a size of 200 beds is a more appropriate threshold for the application of this provision.

⁵⁰See pp. 40-42, and Chapter 27.

⁵¹In accordance with the prototype by-laws of the Ontario Hospital Association, p. (iii).

⁵²R.R.O. 1960, Reg. 523, s. 3.

⁵³*For Your Information*, Bulletin from the Ontario Hospital Association, December 21, 1966, quoted in J. W. Grove, *op. cit.*, p. 75.

⁵⁴Regulation 523 under the Public Hospitals Act as revised by O. Reg. 102/66, s. 2.

The role of the Board has been changing in the past two decades; its traditional fund-raising functions have declined in importance, and it is coming to assume more direct responsibility for the quality of patient care provided in the hospital. But the unwieldy size of the Board, the expertise of the hospital staff, and the complexity of hospital management have made it difficult for the Board to take an active, initiating role in the determination of hospital policy. It has tended to become rather a recipient of proposals from the hospital technocracy, approving or disapproving them as it deems appropriate. The boards of most larger hospitals have attempted to combat the problems of size and lack of expertise by establishing a small Executive Committee, which meets as often as once a week and attempts to play a more active role in the policy-making process.

The Hospital Administrator

The "direct and actual superintendence and charge of a hospital"⁵⁵ is delegated to the Board-appointed hospital administrator, the chief administrative or line official. The administrator's responsibilities under the Board include the enforcement of the above-mentioned legal provisions and the employment, control and direction of all employees of the hospital. Since members of the medical staff (except "house staff") are not *employees* of the hospital, the administrator's authority does not extend to this group. He may, however, advise the chief of the medical staff and/or the Board of any lapse on the part of a physician in complying with legal provisions, such as the keeping up to date of patient records, or in providing a level of patient care satisfactory to the Director of Nursing.⁵⁶ Members of the "house staff" internes and residents are technically employees of the hospital and hence subject to the administrator's authority, usually through the medical director. Since the training of these personnel is in the hands of the medical staff, however, effective control is exercised for the most part by the latter group. In addition to his personnel functions, of course, the administrator is responsible for the "hotel" aspects of the hospital's operation — laundry, dietetic and housekeeping services — and for its financial management.

The growing complexity of the hospital as an institution has led to the development of formal training programs in its management. Two postgraduate university courses in hospital administration are now offered in Ontario, one a diploma course in the University of Toronto's School of Hygiene, the other an M.A. degree course in the University of Ottawa's School of Hospital Administration. The format of both are similar, comprising nine months of formal courses followed by a twelve-month hospital residency. The University of Toronto's School of Hygiene plans soon to change its mode of recognition of its graduates, offering a Master of Hospital Administration (M.H.A.); the date of this change has not yet been determined. In addition to these university courses, the Canadian Hospital Association offers a two-year correspondence program, including two one-month resident summer sessions. In 1965, 20 per cent of the administrators

⁵⁵R.S.O. 1960, c. 322, s. 1(a).

⁵⁶Prototype by-laws of the Ontario Hospital Association, p. 11.

employed in general and allied special hospitals in Canada possessed university degrees or diplomas in hospital administration; another 23.5 per cent had taken extension or correspondence courses. Many administrators have been drawn from the ranks of medical and nursing graduates, although laymen continue to form the majority in the field. The qualifications of hospital administrators in Canada and Ontario in 1965 are given in Table 7.4.

The Medical Director

Some larger hospitals employ, in addition to the administrator, a line official known as the medical director. His role is somewhat ambiguous and varies from hospital to hospital. He is a physician, but he is an employee of the hospital, not a member of the medical staff. In some hospitals he is considered a liaison officer between the administrator and the medical staff, an assistant to whom the administrator delegates those of his functions which relate to the medical staff, the enforcement of relevant by-laws and regulations, and the general surveillance of patient progress and medical attention. He has no clinical authority over individual members of the medical staff; this authority accrues to the chief of the medical staff (see pp. 31-32). Grove notes that one important function of the medical director is to serve as a "listening post", who gathers information regarding the quality of service provided by individual physicians through his contacts with the nursing staff and with internes and residents, through his membership on every standing committee in the hospital.⁵⁷

In 1965, seventy-six of the 1,011 public general and allied special hospitals in Canada employed full-time medical directors; an additional 109 employed such

TABLE 7.4
Qualifications of Hospital Administrators in General and Allied
Special Hospitals,¹ 1965

	CANADA				ONTARIO			
	M.D.	R.N.	No additional qualifications	Total	M.D.	R.N.	No additional qualifications	Total
Degree or diploma	42	40	114	196 (20.0%)	4	11	34	49 (24.0%)
Extension course	2	65	164	231 (23.5)	—	22	52	74 (36.3)
No formal training	56	233	266	555 (56.5)	9	38	34	81 (39.7)
Total	100 (10.2)	338 (34.4)	544 (55.4)	982 (100.0%)	13 (6.4)	71 (34.8)	120 (58.8)	204 (100.09%)

¹Includes public, private and federal hospitals. Based on responses from 99.4 per cent of Canadian general and allied special hospitals.

SOURCE: DBS, *Hospital Statistics, 1965*, Vol. III, Hospital Personnel, Queen's Printer, Ottawa, 1967.

⁵⁷J. W. Grove, *op. cit.*, p. 73.

personnel on a part-time basis. Of the 218 public general and allied special hospitals in Ontario, fifteen employed full-time directors, and thirteen part-time directors.⁵⁸

In line below the administrator are the directors of the various general, special and supplemental services. Of these, the directors of the laboratory and radiology services occupy somewhat anomalous positions and their status varies considerably among hospitals. In some cases these personnel, although medical specialists, hold line positions in formal organizational terms. They are appointed by the Board of Governors, usually on the advice of the Medical Advisory Committee, but their medical staff status may be ambiguous. Although they are usually but not always members of the medical staff as well as occupants of line positions, this membership implies varying degrees of participation in medical staff meetings and responsibility to the chief of the medical staff. In other cases, the laboratory and radiological services are considered as divisions within the departments of pathology and surgery respectively, and their directors are considered heads of divisions, full medical staff members organizationally subject to the chiefs of the latter departments. In practice, these directors enjoy substantial independence within the hospital context. Presumably any gross incompetence on their part would be drawn to the attention of the administrator and the board by the Medical Advisory Committee, with or without the involvement of the chiefs of the relevant departments; but given the relative expertise of the laboratory directors, such action is highly unlikely.

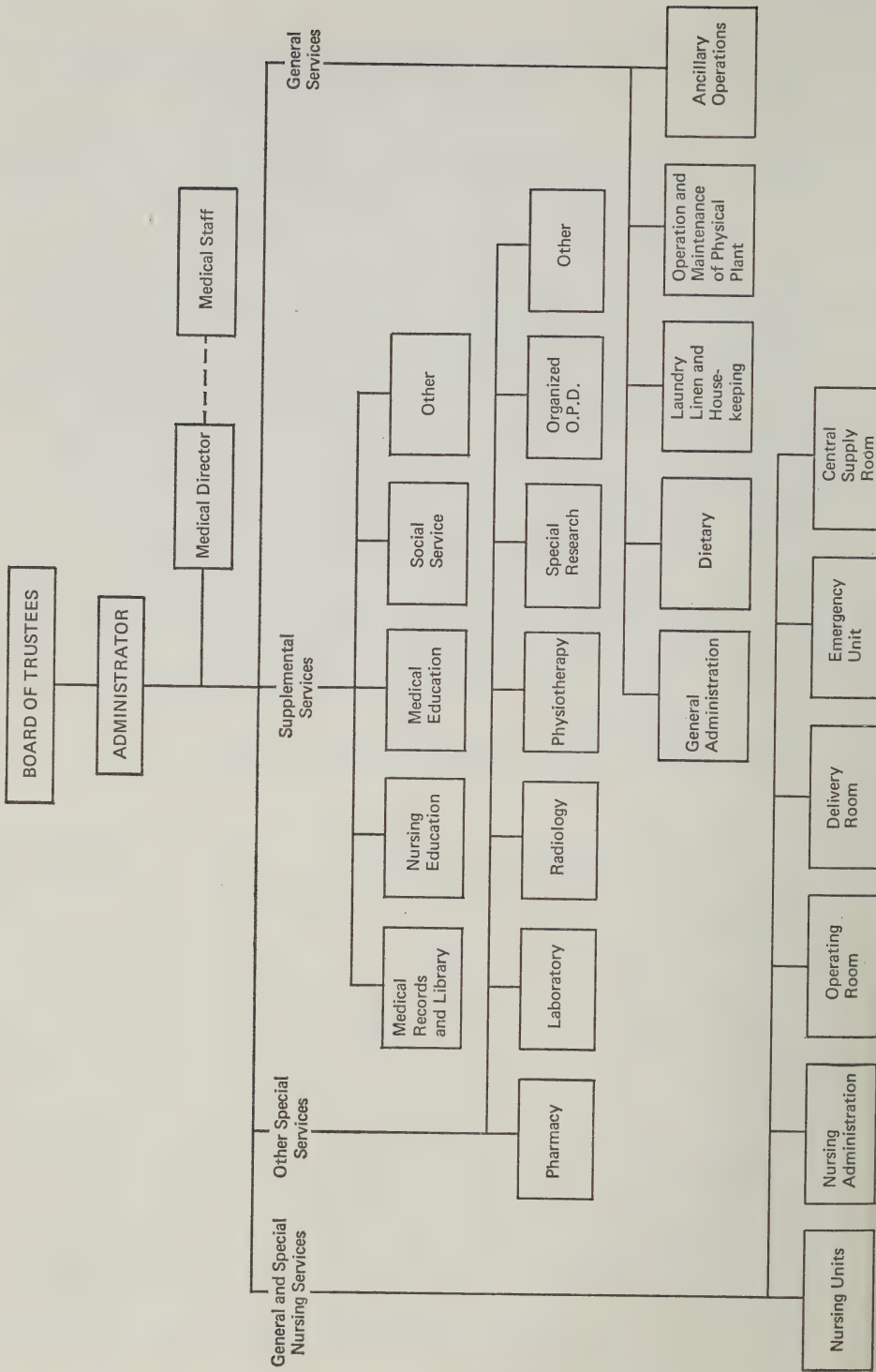
A typical line system is depicted graphically in Figure 7.1.

The Medical Staff

The other system of authority in the hospital is that of the medical staff—in theory an association of independent practitioners organized for the purposes of self-regulation and surveillance of the quality of medical care provided in the hospital. It performs these functions through a network of elected and appointed staff members and committees. This network is constituted according to the by-laws of the individual hospital; but the basic structure, with which these by-laws must comply, is laid down in Regulation 523 passed in 1960 under the Public Hospitals Act. This directive requires the medical staff of each public hospital in Ontario to organize itself into a system of committees for the performance of its regulatory and supervisory functions. The chief among these committees is the Medical Advisory Committee. Except in the case of university-affiliated teaching hospitals, it is elected by the medical staff and formally appointed by the Board of Trustees. In the former case it is appointed by agreement between the hospital Board and the university, and must include the president and the secre-

⁵⁸DBS, *Hospital Statistics 1965*, Vol. III, Hospital Personnel, Queen's Printer, Ottawa, 1967, pp. 60-61. Based on a response rate of 99.4 per cent.

Figure 7.1



tary of the medical staff and the chief of the dental staff. Its duties, according to the regulation, are to

- (a) make recommendations to the board concerning,
 - (i) every application for appointment or re-appointment to the medical staff and to the dental staff, where there is a dental staff,
 - (ii) the hospital privileges to be granted to each member of the medical staff,
 - (iii) the hospital privileges to be granted to each member of the dental staff, where there is a dental staff,
 - (iv) by-laws respecting the medical staff and the dental staff, where there is a dental staff,
 - (v) rules respecting the medical staff and the dental staff, where there is a dental staff,
 - (vi) the dismissal, suspension or restriction of hospital privileges of any member of the medical staff or the dental staff who contravenes any provisions of the by-laws, The Public Hospitals Act, The Hospitals Services Commission Act or the regulations made under those Acts, and
 - (vii) the quality of medical care provided in the hospital;
- (b) provide supervision over the practice of medicine in the hospital; and
- (c) advise the board on any matter referred to it by the board.⁵⁹

The regulation also provides for the establishment of other committees, to be discussed below, to assist the Medical Advisory Committee in the performance of these functions. The establishment of these committees may take the form either of their appointment by the Board on the recommendation of the medical staff, or of their direct election by the medical staff. Upon this basic framework, individual hospitals have worked several variations. Most, for example, have provided for a chief of the medical staff, to be appointed by the Board and charged with the general supervision of all clinical care provided within the hospital. We should note here that the chief of the medical staff is not to be confused either with the medical director, discussed above, or with the president of the medical staff. The latter is elected by the medical staff to represent their interests in dealing with hospital officials. His election, as well as that of a vice-president and a secretary of the medical staff, is provided for by Regulation 523; and, along with the vice-president and the chief of staff, he usually enjoys *ex officio* representation on the Board of Trustees. The practice concerning the chairmanship of the Medical Advisory Committee varies among hospitals. It may be held either *ex officio* by the president of the medical staff or the chief of the medical staff, or by another physician altogether. At the risk of considerable oversimplification, then, we may summarily characterize the roles of these various medical officials. The chief of staff is the official liaison between the Board of Governors and the medical staff, and bears ultimate responsibility for the quality of medical care provided in the hospital; the president of the medical staff is the elected representative of the physicians practising in the hospital; and the medical director, where this position exists, is the administrator's assistant for medical affairs.

⁵⁹R.R.O. 1960, Reg. 523, s. 6(6).

An important variation upon the basic structure is the system known as clinical departmentalization. The decision to departmentalize is taken not so much on the basis of the *size* of the hospital as on the "professional resources" of the medical staff — that is, the number of its members with training and experience in the various specialties. The staff may be fully or partly departmentalized. The three basic departments are medicine, surgery and obstetrics;⁶⁰ beyond this, the departments of medicine and surgery may be subdivided into *services* corresponding to medical and surgical specialties. Again depending upon "professional resources" available, the medical staff may prefer to organize the clinical specialties as departments, or to establish them initially as services to be removed gradually from the aegis of their parent departments and graduated to coordinate status. Where departmentalization is in effect, appointments are made not to the medical staff at large, but to the individual divisions. Each service and department is headed by an appointed head or chief who is responsible for the general supervision of the clinical care provided by the members of his staff. Another form of supervision is the review of the clinical activities of the members of the department at its monthly meetings. The uniformity of procedure fostered by this supervision is especially important for the discharging of the department's educational functions, the training of internes, residents, and, to a lesser extent, nurses. The power to establish departments and services and to appoint their heads lies formally with the Board but is exercised on the advice of the Medical Advisory Committee.

Of particular interest in this connection are hospital departments of general practice. This form of organization is becoming popular as one way of attempting to reverse the unfortunate trend towards the exclusion of the general practitioner from the hospital. The College of Family Physicians has advanced the view that:

For a Family Physician to function effectively within the hospital, to assume his full responsibility, and to appreciate adequately the rules and regulations governing his participation in hospital activities, he must be a part of the hospital organization in some formal way. This can best be done through the organization of a Department of General Practice; where departmentalization is appropriate.⁶¹

The College of Family Physicians itself lays down very flexible guidelines for the organization of such a department. It may be responsible for, or at least co-operate in, the organization and staffing of the emergency and outpatient departments, and may administer discrete units for family practice, outpatient clinical teaching, inpatient clinical teaching, clinical assessment, rehabilitation, and ambulatory care. The relationship between the emergency and outpatient departments and the department of general practice varies widely from total control (with the directors of the outpatient department and emergency services designated by and

⁶⁰The prototype by-laws of the OHA list general practice as one of the basic departments; but this constitutes a proselytization of this form of organization, rather than a description of usual practice.

⁶¹*Manual on Departments of General Practice in Hospitals*, College of General Practice of Canada, September 1967, p. 1.

responsible to the head of the department of general practice) to part-time assistance and informal consultation with members of the nursing staff or with specialist colleagues. The clinical activities of the department of general practice are usually limited to outpatient and emergency responsibilities; the department itself does not usually operate an inpatient clinical service. The Canadian Council on Hospital Accreditation recommends that the department of general practice not operate an inpatient clinical service, but suggests that "at all regular meetings of the Department of General Practice there shall be a review and analysis of clinical work at which there shall be a discussion of current or recent cases which were attended in the Hospital by members of that department".⁶² Moreover, as noted below, general practitioners may have privileges in other departments or services, under the jurisdiction of the specialist head of that department and subject to its regulations. The department also has administrative responsibilities (having representatives on the various medical staff committees) and educational functions, in particular with regard to internes and nurses.

In 1967 the College of Family Physicians of Canada (then the College of General Practice of Canada) conducted a survey of all general hospitals in the country in an attempt to discover which of the departmentalized hospitals had established departments of general practice. Of the ninety-five hospitals in Ontario which responded, sixty-nine were departmentalized, and of the latter fifty-four had established departments of general practice. Of the fourteen responding Group A hospitals, four, all in the Toronto area, had not established departments of general practice.⁶³ Since 1967 one of these hospitals (Sunnybrook) has established a department of general practice.

The self-policing activities of clinical departments are supplementary to the compulsory medical audit, performed by the network of medical staff committees outlined in Regulation 523. These committees control the physician's initial and continuing access to the hospital and the limitations to be placed upon his practice within the hospital, supervise his compliance with hospital and statutory regulations and the quality of clinical care which he provides, and discipline him for failure to meet standards in all these areas. General supervision, as noted, is provided by the Medical Advisory Committee, which considers and acts upon the recommendations of a number of "subcommittees". The establishment of committees on credentials and records is compulsory under Regulation 523, as is the setting up (in hospitals with ten or more members on the active medical staff) of admission and discharge and medical audit committees. Beyond this compulsory structure, individual hospital medical staffs may create such further committees as are deemed necessary. The functions of the major committees may be delineated as follows:

⁶²Canadian Council on Hospital Accreditation, Accreditation Guide No. 3, p. 7.

⁶³Information submitted to the Committee on the Healing Arts by the College of Family Physicians, January 1969. In addition, three *non-departmentalized* hospitals reported having departments of general practice.

The *credentials committee* processes all applications for hospital privileges and makes recommendations for the type and extent of privileges to be granted to each physician. Appointments to the medical staff are reviewed periodically by this committee.

The *tissue committee* examines pathological reports of all tissues removed surgically in the hospital and examined by a pathologist, as a verification of each surgeon's decision to operate. Either the tissue committee or the medical audit committee also reviews all operations in which no tissue was removed.

The *medical audit committee* reviews medical reports, pre- and post-operative diagnoses and other measures and provides a standard method of evaluation of the medical care provided by physicians.

The *medical record committee* studies the quality of the patient record kept by physicians.

The *admission and discharge committee* studies patient records with an eye to determining the necessity and the duration of patient stays.

There is considerable overlapping membership, both informal and formal, among these committees; the chairmen of these five "subcommittees", for example, are usually members of the Medical Advisory Committee. The departmental structure, where it exists, is well coordinated with this committee structure: each department is represented on each, and the heads of departments are members of the Medical Advisory Committee. The following excerpt describes a typical situation at a large departmentalized hospital:

. . . In cases where a doctor may exhibit doubtful standards of practice, these are referred to the Chief of the Clinical Department and indeed all . . . studies are referred to the Clinical Department concerned for the information of the Chief and the Department. . . . In addition, individual cases do come to the attention of the Medical Advisory Committee or the Executive Committee of the Medical Staff, and the Chief of Staff or the Chief of the Clinical Department may deal with those cases personally.⁶⁴

In bringing such "individual cases" to the attention of the appropriate members of the medical staff, the administrator or the medical director can perform a useful monitoring function.

Medical staffs and hospital administrators may now be aided in the increasingly complex task of the evaluation of clinical care by two recently established institutes using cybernetic techniques to evaluate hospital records. The Hospital Medical Records Institute (HMRI) was established in 1963 by the Ontario Medical Association, the OHA, and the Ontario Association of Medical Record Librarians. To avail itself of this aid, a hospital translates its records into the Institute's coding system. The records are then processed at the Institute, using the OHA's computer facility, to produce a number of summary indices and analyses: 1) a patient listing, 2) a diagnosis index, 3) an operation index, 4) a physician's index, 5) service analyses, 6) hospital totals, 7) death listing. The

⁶⁴Ottawa Civic Hospital, reply to Questionnaire "D", Committee on the Healing Arts.

service is available on a voluntary basis and is now utilized by eighty Canadian hospitals, over one-half of which are in Ontario. A few hospitals in Ontario participate in a similar but much more extensive and sophisticated program, the Professional Activities Survey and Medical Audit Program (PAS-MAP), carried on by the Commission on Professional and Hospital Activities⁶⁵ in Ann Arbor, Michigan. PAS, which forms the core of the program, is similar to HMRI in that it is based upon abstracts from individual patient records, but differs in providing cross-hospital data and indices for purposes of comparison. MAP provides a more extensive review of *all* medical care in the hospital. Approximately 2,000 hospitals in five countries participate in the PAS-MAP program.

The efficacy of the entire process of self-review, of course, depends upon the ultimate disciplinary power of the Medical Advisory Committee. The sanctions wielded by the committee in effecting this power derive from its control of hospital privileges, which it may grant, delimit, restrict, suspend or refuse. A finding of delinquency or incompetence by the Medical Advisory Committee or one of its "subcommittees" may result in the restriction or suspension of the hospital privileges of the physician concerned, actions which may in effect deprive him of his practice, especially if he is a specialist relying on the complex diagnostic and therapeutic equipment of the hospital. An amendment to the Public Hospitals Act in 1965 requiring that all such disciplinary actions be reported to the College of Physicians and Surgeons of Ontario increases the effectiveness of the Medical Advisory Committee, reducing as it does the likelihood that the disciplined physician may secure appointment to another hospital medical staff. This requirement may, however, have reduced the likelihood that medical staff will take disciplinary action against a colleague. A recent (1966) amendment to the Public Hospitals Act requires that, in cases where a physician's care of his patient is deemed unsatisfactory, the chief of the medical staff, or where the staff is departmentalized, the chief of the relevant service, take over the care of the patient.⁶⁶

The matter of hospital privileges is of central importance in any consideration, not only of the practice of medicine, but of the education and regulation of physicians. It is an issue, moreover, with implications extending beyond the medical profession to involve other health professionals. Recognizing its importance, we shall postpone discussion of this topic until it can be taken up at greater length and in a broader perspective in Chapter 27.

Salaried Medical Staff

The distinction between the two systems of authority in the hospital is muddled by the operation of one of the more striking trends in hospital organization in recent years: the steady increase in the number of medical personnel formally employed by hospitals. As radiologists, pathologists, medical directors, clinical

⁶⁵Sponsored by the American College of Physicians, the American Council of Surgeons, the American Hospital Association, and the Southwest Michigan Hospital Council.

⁶⁶S.O. 1966, c. 126, s. 4.

teachers,⁶⁷ internes and residents, more and more holders of M.D.'s are accepting salaried positions in hospitals. S. Judek, in his study of medical manpower in Canada, reported a 150 per cent increase in the number of such personnel between 1951 and 1961.⁶⁸ In Ontario alone, the number of medical personnel employed full time in public general hospitals increased over 50 per cent between 1961 and 1967.⁶⁹ Part-time appointments, on the other hand, have not shown a corresponding consistent increase.

Another form of salaried practice in hospitals is beginning to emerge in the large hospitals. The spread of hospital insurance means that many patients who would formerly have been "charity cases" are now sources of income for the physicians who treat them. In some hospitals this income from public ward patients is pooled and redistributed in the form of salaries and support for research, in a form of de facto group practice. The arrangements whereby this redistribution is effected are now largely informal and in a state of evolution; the process is usually accomplished at the discretion of department heads.

Nursing and Paramedical Staff

The nursing staff of the modern general hospital, unlike most of the medical staff, has a direct employer-employee relationship with the hospital itself. At one time, the director of the nursing staff reported directly to the Board of Trustees; but with the development of the professional hospital administrator's position, the practice today is for the director of nursing to report to the administrator. The line organization of the nursing staff itself thus presents an apparently simple devolution of responsibility from the administrator to the director of nursing, and through her down to the head nurses in charge of wards or nursing units to the staff nurses and nursing assistants.

Two factors, however, greatly complicate this simple picture in practice. One is the strongly held but ambiguously defined professional status of the nurse. To the extent that nurses are professionals (see Chapter 10), nurses have some professional responsibility. This may dispose them to expect to be treated rather differently than other employees of the hospital, such as cleaners, caretakers and laundry workers. Yet this claim to professional status is weak in comparison to that which enables physicians to operate independently, subject mainly to their own peer group discipline and organization. The nursing staff apparently does not expect to achieve similar status in relation to the institution. We find, then, that to the extent patient care falls within the special competence of the nursing profession, the procedures involved are determined largely by directors of nursing and head nurses in individual institutions. Yet they in turn are not strongly influenced by the College of Nurses, or other professional nursing body, in determining their policies the way physicians are by their professional organizations.

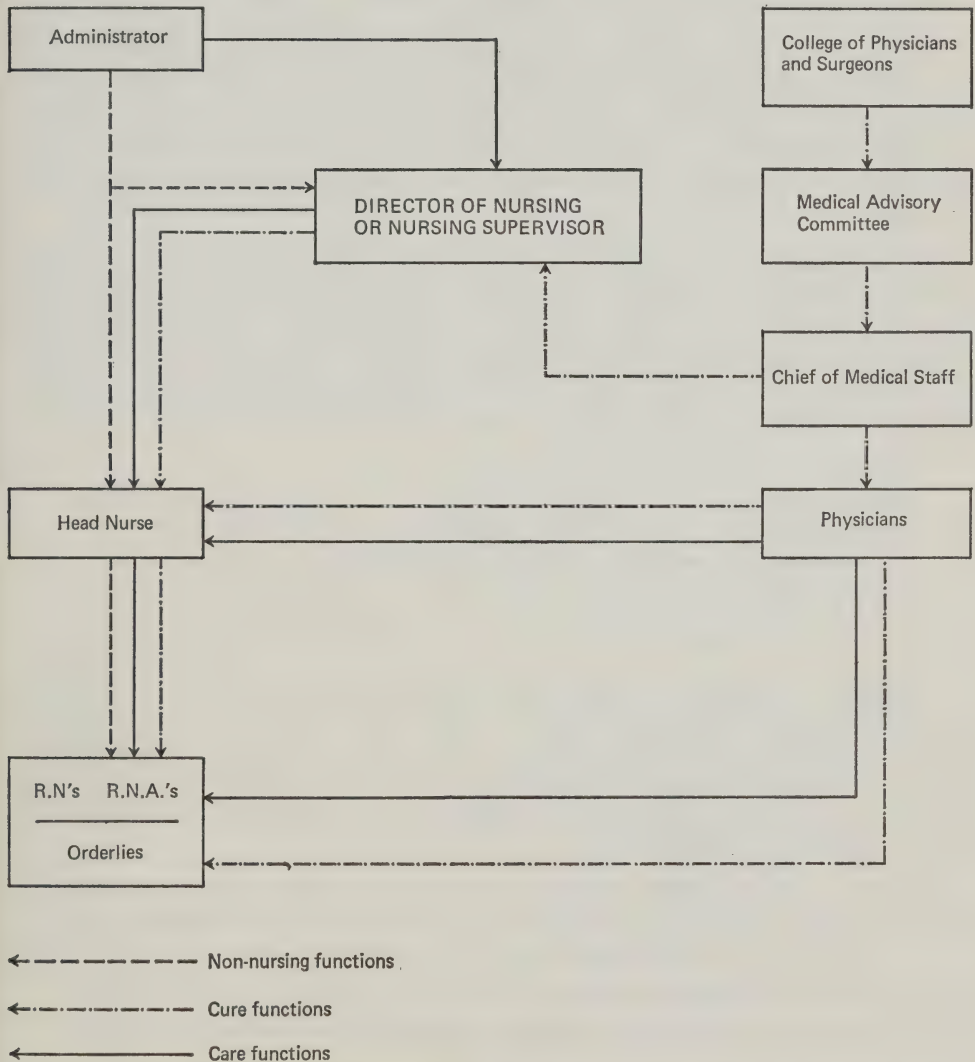
⁶⁷See the discussion of the method of remuneration of clinical teachers in Chapter 27.

⁶⁸S. Judek, *Medical Manpower in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 190.

⁶⁹OHSC, *Annual Report (Statistical Supplement)*, 1961, 1967.

The second complicating factor is related to the first. Because the medical staff answers to itself in large measure, and does not function under the hospital administration's direct control, it does not necessarily work through the administration in its relations with the nursing staff. It is evident that physicians give orders to nurses directly. The medical staff consequently cuts into the line organization of the nursing structure at any point it finds convenient. One reason for this is that part of the nursing function is "curative" and therefore supposedly lies outside

Figure 7.2



SOURCE: Based on V. V. Murray, *Nursing in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Ch. 3.

the area of the special professional competence of the nursing staff. These curative functions must remain the ultimate responsibility of the medical staff of the hospital. Thus, as indicated in Figure 7.2, physicians may give instructions to staff nurses and head nurses directly, without reference to the director of nursing services. At the same time, the organized medical staff of the hospital establishes general codes of nursing "curative" practices through the general responsibility of the Medical Advisory Committee for the medical services provided in the hospital. These codes in turn are governed by the policies laid down concerning the medical procedures which can be delegated to nurses (and other hospital personnel) by the College of Physicians and Surgeons of Ontario.

Finally, it must be recognized that some work done by nurses in hospitals is of a clerical, housekeeping or otherwise "non-nursing" nature. Consequently the nursing staff is subject to the wishes of the hospital itself as to how these duties are to be performed. Although the practice varies, it is common for the hospital administrator, or someone in his office, to deal directly with head nurses on the wards or in nursing units, to regulate the performance of these functions.

We have seen that in addition to their nursing staff, modern hospitals require a large and growing number of specialized paramedical workers. Like the nursing staff, the members of some paramedical departments have recognized areas of professional competence in which they may be largely independent of the medical staff and even of the hospital administration. Yet, again like the nurses, they lack the kind of professional independence which distinguishes the medical staff from all other groups in the hospital setting.

The paramedical departments stand somewhere between the strictly administrative departments and the medical departments . . . they have a relatively high degree of autonomy in pursuing their objectives. To a large degree they are self-policing, and are not supervised directly by the administrative staff of the hospital. They do not, however, have the ultimate type of professional autonomy characteristic of the medical practitioners.⁷⁰

The organization and the degree of autonomy possessed by these paramedical departments varies from one hospital to another. And within each hospital, different paramedical departments will be organized in different ways. Hall has usefully identified⁷¹ three main categories of paramedical occupations on the basis of which we may also classify the various types of paramedical departments found in general hospitals today:

- 1) Technical occupations. These are occupations which arise from the technical complexity of modern medicine. Scientists and technicians working in hospital laboratories would be typical and, in terms of numbers, important examples of those who work in such occupations.
- 2) Specialized treatment occupations. Physio and occupational therapists

⁷⁰O. Hall, *op. cit.*, p. 11.

⁷¹*Ibid.*, p. 10.

and other workers who provide certain forms of treatment which they are specially trained to carry out without direct medical supervision.

- 3) Those occupations which have to do with providing services both to the medical staff and to the hospital. Medical record librarians are good examples of such workers.

Using the examples given of each of these three types of paramedical services, it may be useful to indicate briefly the forms of administrative arrangements to which they are subject.

The Laboratory Services

Like other non-medical departments, the hospital laboratories are subject to a dual line of authority, the medical and the administrative. Larger hospitals usually have full-time medical directors for the laboratory departments. These are physicians who are members of the medical staff of the hospital. They take responsibility for the medical quality of the work done in their particular laboratory be it bacteriology, haematology, biochemistry, or other. Some hospitals, however, may have a physician in charge of a pathology laboratory, but only head technicians in charge of each of any other laboratories in the hospital. And even when there is a medical doctor in charge of a laboratory, his control may be merely formal, with the active responsibility for maintaining the quality of work done in the laboratory resting with a head technician or a university educated scientist. As Hall observes:

Evidently, the real responsibility for producing accurate results rests with the technicians themselves — the charge technician and his staff. In almost all the laboratories the head technician checks the written reports on the tests before they are passed up the line. In a few cases, he also supervises the work in process; but, for the most part the technicians work by themselves, relying on their own judgement to produce accurate results.⁷²

Physiotherapy

Physiotherapy, like the other branches of what is coming to be known as "rehabilitation medicine", is an inherently difficult service to organize within a typical hospital administrative system. Because therapy is highly particular to the individual patient's condition, it is not easily subjected to formal controls or direct supervision. Furthermore, physiotherapists who are university trained tend to think of themselves as responsible "professionals". Their ability to function as individual practitioners is enhanced by the way they become scattered through the hospital in the course of their work, rather than being concentrated in laboratories or other specific locations like most of the technicians.⁷³

Direct supervision of the work done by physiotherapists may be provided by a "physiatrist" — that is, a medical specialist in physical medicine — who heads the

⁷²*Ibid.*, p. 28.

⁷³*Ibid.*, p. 110.

physiotherapy department. The numbers in this specialty are very limited, however; and in most cases supervision is provided in the absence of a physiatrist by "chief therapists" and by the doctors whose patients are being treated. Physicians may be limited in their ability to perform this supervisory function by their lack of knowledge concerning precisely what it is that physiotherapists are able to do.

Internal organization of physiotherapy departments in hospitals follows no set pattern. "The number of levels of authority relates directly to the size of the department, and the types of rehabilitation medicine done in it."⁷⁴ In some hospitals distinctions are drawn in terms of authority and responsibility among chief, assistant chief, and staff physiotherapists. In large teaching hospitals there may be a chief physiatrist or medical director in charge of the physiotherapy department.

Medical Record Librarians

The medical record librarians serve a dual function: maintaining a continuous record of each patient for the attending doctor's use, and providing material for research being done by the medical staff. These tasks fall somewhere between the highly technical work done by technicians in the laboratories and the independent "professional" work done by physiotherapists, occupational therapists, and speech therapists. The medical record librarians are trained in twelve-month diploma courses given in hospitals.

The organization of medical records departments generally seems to be casual, with administrative responsibility delegated by the hospital authorities to a chief librarian who appoints assistants and delegates their responsibilities to them. In Roman Catholic hospitals, "Sisters" are often the senior departmental administrative officers, with the lay staff taking their orders from them. This is a common pattern for a number of paramedical departments in Roman Catholic hospitals.⁷⁵

The medical record librarians have close contact with the medical staff, but there do not appear to be formal relationships whereby the medical staff is given authority to influence the work of the medical records department. Indeed, one of the responsibilities of the department involves initiating disciplinary action against members of the medical staff who are derelict in their duties relating to completing charts and maintaining accurate records of their work. In some hospitals a "chart committee", comprising doctors and medical record librarians, reviews charts for inadequacies.⁷⁶

Conclusion

Having surveyed both the various functions of the modern hospital and the formal aspects of its organization, we are in a position to reassess the concept of the hospital as the physician's workshop, and to anticipate our further discussion

⁷⁴*Ibid.*, p. 107.

⁷⁵*Ibid.*, p. 98.

⁷⁶*Ibid.*, pp. 99-100.

in the next volume, in which we consider several issues involved in the hospital's role in the health system as a whole.⁷⁷ The responsibility for the quality of treatment provided in the hospital can no longer be considered, *de facto* or *de jure*, to rest with the medical profession alone. The modern hospital does much more than provide the physician with the facilities of his craft. As we have seen, it educates, regulates, conducts research, and most importantly, *provides medical care*. In other, more controversial words, the modern hospital in a real sense "practises medicine".⁷⁸

This "corporate practice of medicine" is most clearly seen in the emergency department of the hospital, where a patient may be seen by a nurse, interne or resident *only*. Nurses and internes, as we have seen, are considered employees of the hospital. Residents are nominally under the supervision of respective chiefs of service, they are full-time salaried members of hospital house staff, and their activity in the emergency department is largely unsupervised.

What applies in the emergency department also applies in varying degrees throughout the hospital. More and more care is provided by *employees* of the hospital — medical, nursing and paramedical — who, in the administrative scheme, come under the line authority of the administrator. The relationship of these personnel to the medical staff varies greatly among hospitals and indeed among individuals. Traditionally, paramedical personnel have been subject to the authority of individual physicians in the handling of clinical cases, but a dominant and senior director of nursing or a highly skilled physiotherapist, for example, can distort the formal organizational chart in administrative matters and bend the lines of professional influence in clinical matters. Moreover, the distinctions among "curative" and "care" functions and administrative matters are not always clear, and the lines of authority are further tangled. In general, however, the physician has regarded paramedical and auxiliary personnel as the human facilities provided by the hospital to aid him in the provision of care to his patients, subject as such to his absolute authority in clinical matters. But as we repeat throughout this Report, the modern physician in the various aspects of his practice is a member, albeit the central member, of increasingly complex teams of health personnel. The hospital team is the most extensive of these, including specialist and general physicians, dentists, nurses, radiological and laboratory technicians, physio and occupational therapists, pharmacists, and social workers, often at "trainee" as well as fully licensed levels. The regulation and supervision of this large body of personnel can no longer justifiably rest with one profession. In practice the supervision of and responsibility for the quality of care provided in the hospital does not rest with its medical staff alone.

⁷⁷See Chapter 27.

⁷⁸That this fact is coming to receive legal recognition constitutes a validation of its sociological reality.

The disparity between the theory and the reality of the practice of medicine in the hospital would not be so serious were it not for its corollary implications for the power structure. It makes for a confusion of lines of authority, a confusion too often resolved in the direction of medical domination. We shall return to this discussion in Chapter 27. Here it will suffice to record our firm conviction that the formal organizational and regulatory aspects of hospital management must be revised to take cognizance both of the hospital's development into a multi-functional institution and of the physician's changing role.

Chapter 8 Physicians

At the apex of the pyramid of personnel involved in the provision of health care are the members of the medical profession. The professional functions of this group, and the mechanisms whereby it regulates and reproduces itself have consequences reaching far beyond its own membership; an understanding of these factors is essential to the analysis of all forms of health care delivery in the province.

The Committee early in its deliberations decided that it would commission a number of studies of professions or disciplines and of institutions pertaining to health. One of these studies, by J. W. Grove, *Organized Medicine in Ontario*, published as a separate volume, is a most important adjunct to this chapter.¹

The medical profession is the oldest and most senior group within the health professions, and the physician traditionally has been regarded as the central and most essential figure in the provision of health services. The role of the physician has undergone considerable change in recent years, and will continue to do so. "Medicine is a social institution and, like any other, is subject to the social forces affecting change."² But the well-established functions of the medical profession have been the linchpin of the health system, conditioning and shaping the evolution of the related health professions and disciplines. Because the organization of the medical profession has provided a model or standard for other disciplines, it is appropriate to subject this profession to a particularly detailed scrutiny which may enable us better to understand the whole complex of health problems. Therefore, we will analyze this discipline at some length, remembering always the implications of this profession for other related disciplines and for the totality of the health system.

In recognition of the number and complexity of the issues here involved, and to sharpen the focus of our exposition, we have analyzed the medical profession by first briefly setting it in historical perspective, and then proceeding against this background to discuss its changing role, manpower supply, educational arrangements, regulatory structure, and its internal mechanisms of quality control.

History

Medical practice in Canada developed, within the constraints of the frontier society, along lines parallel to the development in Britain. Although the British colonies

¹J. W. Grove, *Organized Medicine in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969.

²E. G. Jaco, "Twentieth Century Attitudes Toward Health and their Effect on Medicine" in L. J. DeGroot, M.D., *Medical Care: Social and Organizational Aspects*, C. C. Thomas, Springfield, Illinois, 1966, p. 13. See also J. W. Grove, *op. cit.*, Ch. 1, for an excellent discussion of "trends in medical service and medical practice".

were from the first autonomous with respect to professional regulation,³ the British influence was transmitted through immigrant physicians and through Canadians who trained in Britain, bringing British techniques, both in practice and in organization, to the Canadian scene. The frontier, however, did make for some differences in Canadian medical practice. One of its effects was the exaltation of the position of the general practitioner as the sole medical stay of an isolated community, and the consequent retarding of the development of specialization. Even the distinction between medicine and surgery, long a source of professional antagonism in Britain, "remained indistinct until well into this century".⁴ William Reader has reported that in the third quarter of the nineteenth century in Britain, "specialization ceased to be looked down upon as an affair of quacks as it had been in the thirties, and became highly respectable, besides becoming more profitable than general practice".⁵ MacDermot, however, reported in 1967 that "specialists, as now understood, did not exist less than a hundred years ago in Canada",⁶ and in 1881 the Canadian Medical Association could resolve that:

Whereas the system of specialism and specialists, which at present obtains to a certain extent in the Dominion, and which has developed to a very large proportion in the neighbouring republic, is for the most part the outgrowth of superficial professional education and a want of success as practitioners of medicine and surgery; therefore be it resolved, That it is the opinion of this society that specialism should be discountenanced by the members of the society; and that specialists except in rare cases . . . should be treated and looked upon as irregular practitioners.⁷

The emphasis upon generalization was necessitated by the virtual isolation of a large proportion of the physicians. In 1871, there were fewer than 3,000 physicians in Canada to care for a widely scattered population of 3,700,000.⁸ Hospitals were for the most part confined to urban centres; the operating room for the pioneer physician was often the kitchen of the patient's home. Even where hospitals were accessible, assistants were few and lacked formal training; but the latter condition, it must be admitted, applied to an unknown but substantial number of practising physicians as well.⁹

In such a situation, medical education, particularly in the first half of the nineteenth century, tended to be an individual affair; few Canadian physicians shared a common educational background. The would-be physician either apprenticed himself to a practitioner or sought formal education in institutions of medical education in Britain or on the Continent. Chief among these was the Medical Faculty of the University of Edinburgh, of which a very large number of the early

³See generally R. H. Shyrock, *Medical Licensing in America, 1650-1965*, Johns Hopkins Press, Baltimore, Maryland, 1967.

⁴The situation in the United States was similar. *Ibid.*, pp. 8-9.

⁵W. J. Reader, *Professional Men*, London, 1966, p. 166.

⁶H. E. MacDermot, *One Hundred Years of Medicine in Canada, (1867-1967)*, McClelland and Stewart Ltd., Toronto/Montreal, 1967, p. 40.

⁷Quoted in J. W. Grove, *op. cit.*, p. 45.

⁸H. E. MacDermot, *op. cit.*, p. 19.

⁹*Ibid.*

Canadian professors were alumni. Teaching hospitals in London and France were popular centres as well. Of 260 physicians whose biographies appear in Canniff's *History of the Medical Profession in Upper Canada from 1783 to 1850*, seventy were graduates of Scottish, forty-three of English, twenty-eight of Irish and forty of American universities.¹⁰ In Lower Canada, of course, the figures would reveal a much greater incidence of French training. Until World War I, Austrian and German centres were also popular for postgraduate training.

The development of indigenous centres of medical education in Canada, as elsewhere, was characterized by problems of dispersed responsibility, resulting in lack of coordination and standardization, and by successive attempts at their resolution. The informal system of individual apprenticeship was giving way, by the mid-nineteenth century, to more formalized and institutionalized methods of training. Formal medical education began in Canada with the founding in 1824 of the Montreal Medical Institution (later to become the Medical Faculty of McGill University), and in Ontario, with the establishment of both the Toronto School of Medicine and the Faculty of Medicine, University of Toronto in 1843.

As the nineteenth century progressed, North American medical education was marked by a proliferation of private medical schools, the infamous "diploma mills", and the possession of an M.D. degree could not be considered necessarily to signify the attainment of a respectable standard of medical competence. The intensification of these problems in North America throughout the latter half of the nineteenth century culminated, in the early twentieth century, in the commissioning and implementation of the revolutionary Flexner Report,¹¹ which remains the basis of medical education in the United States and Canada. The Canadian method of institutionalization offered two important advantages over the American for the quality and standardization of medical education: control of the right to practise had been vested since Confederation in the provincial licensing bodies which exercised their authority from the beginning;¹² and, with few and brief exceptions,¹³ medical education had been provided by medical faculties of universities and not by private medical schools. The more basic structural reforms proposed by Flexner, delivering medical education into the hands of the universities, were largely unnecessary in Canada, although the upgrading of the quality of medical

¹⁰*Ibid.*, p. 112.

¹¹Abraham Flexner, *Medical Education in the United States and Canada*, The Carnegie Foundation for the Advancement of Teaching, Bulletin Number Four, New York City, 1910.

¹²See the more extensive treatment of the development of licensing requirements in Elizabeth MacNab, *A Legal History of Health Professions in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970.

¹³The Toronto School of Medicine, established in 1843, was amalgamated with the Faculty of Medicine of the University of Toronto in 1887. The Faculty of Medicine of Queen's University, established in 1854, existed from 1865-1891 as the Royal College of Physicians and Surgeons, loosely affiliated with the university. The London Medical School, established in 1881, existed until 1912 as a self-governing independent institution affiliated with the University of Western Ontario only for the purpose of granting degrees. In the latter year it became fully integrated with the university, perhaps as a result of the Flexner report.

education was necessary in Canada as in the United States. The problems of dispersed responsibility are less acute in this century, but in different form, as we shall see, they remain fundamental to our system.

Although in the development of institutions of medical education Canada lagged considerably behind Europe, the lag in the development of professional organization was not so great. In his study of medical organization in Ontario, Grove notes that "although medicine is one of the oldest of the arts, its existence as an organized profession dates only from about the middle of the nineteenth century".¹⁴ The British Medical Association was founded (as the Provincial Medical and Chirurgical Association) in 1832 as an association of qualified practitioners, determined to consolidate and promote professional status. The formation of the first medical society in the thirteen American states at Sharron, Connecticut in 1779, marked the beginning of a process in the United States climaxed by the founding of the American Medical Association (AMA) in 1847.

Medical societies appeared in Canada as early as 1826. In Ontario, the Medical Chirurgical Society of Upper Canada was founded in York in 1833, eventually to become the Toronto Medical Society in 1878 and to merge into the Academy of Medicine, Toronto, in 1912. The federating spirit of 1867 encouraged the larger societies in Ontario and Quebec to undertake in that year the foundation of the Canadian Medical Association (CMA). And in 1881 the organizational hiatus between the local societies and the CMA was filled with the formation of the Ontario Medical Association (OMA). In the twentieth century, the growing specialization of work-place and function within the profession gave rise, as noted below, to the proliferation of professional societies.

State recognition of medical qualifications began on a national scale in Britain with the passing of the Apothecaries Act in 1815, a landmark piece of legislation which empowered the Society of Apothecaries to determine the qualifications for the use of the title "apothecary", although it did not forbid practice by the unqualified. It was not until 1858, however, that similar authority was extended by the Medical Act of that year to the existing twenty-one bodies certifying medical practitioners, whose licentiates were henceforth entitled to registration with the newly established General Council of Medical Education and Registration. This Council, however, did not possess "licensing" power as we shall use the term; practice was not then, and indeed has never been, restricted to qualified practitioners, although more and more severe restrictions have been placed on unqualified practice. The United States was initially bolder than the mother country in experimenting with state-sanctioned licensing agencies, beginning in New York City in 1760 and in New Jersey in 1772. By 1830 all states but three licensed either through medical societies or through state examining boards. According to Shyrock, however, for half a century after 1820, the regulation of medical practice in the United States deteriorated, reaching the nadir in the 1850's, when measures

¹⁴J. W. Grove, *op. cit.*, p. 14.

abroad were beginning to succeed. The state governments delegated licensing authority to the medical societies, but the de facto authority was in the hands of the medical schools, which were of highly varied and often inferior quality.¹⁵ Towards the end of the century, however, some standardization began to occur with the formation of the National Confederation of State Medical Examining and Licensing Boards in 1891. The National Board of Medical Examiners was set up as a voluntary, not a statutory, organization in 1915 and began conducting examinations one year later.

Statutory licensing was later to come to Canada, but more successfully adopted when it did. After several abortive attempts to enforce such legislation in the first half of the nineteenth century, the Medical Act of 1865 in Upper Canada established the General Council of Medical Education and Registration, seven years after the establishment of such a body in England. Unlike the English Act, moreover, the Upper Canadian Act imposed a fine for unregistered practice and, more importantly, conferred privileges which could be exercised only by those properly registered. In 1866, another Act transformed the Council, enlarged to include homeopaths and eclectics,¹⁶ into the College of Physicians and Surgeons and empowered it to examine applicants as a condition of registration. The Act of 1866 was re-enacted after Confederation, in the Ontario Medical Act of 1869 which, though amended since from time to time, was the basic legislation for the control of the practice of medicine in Ontario.

In 1912 a national body, the Medical Council of Canada (MCC), was established under the Canada Medical Act. This Act, placed on the statute books in 1907, provided for the establishment of a Council whose purpose was "to promote and effect the establishment of a qualification in medicine, such that the holders thereof shall be acceptable and empowered to practise in all provinces in Canada".¹⁷ It went into effect only after five years of difficult negotiation, however, since it took that long to obtain the agreement of all the provinces to accept such a qualification.

Since 1912, registration on the Canada Medical Register, kept by the Medical Council of Canada as a list of all those who have passed its examinations and (since 1954)¹⁸ who have completed a one-year internship to the satisfaction of a provincial medical council, has been *sufficient* to obtain a provincial licence although in Ontario until 1934 an alternative was available in provincial examinations. It is a *necessary* condition for licensure in Ontario (since 1934), British

¹⁵R. H. Shyrock, *op. cit.*, p. 108.

¹⁶This provision placated the homeopaths and eclectics for a time, but conflict continued throughout the latter half of the nineteenth century, until the problem was solved by the gradual decrease of these two professions. No eclectic was ever examined by the College and representation ceased in the 1870's. Homeopaths were represented on the College Council until 1960. As of 1969 there were six homeopaths registered with the College. For a further discussion of homeopathy, see the Appendix to this chapter.

¹⁷R.S.C. 1952, c. 129, s. 5.

¹⁸Regulations of the Medical Council of Canada, s. 43.

Columbia and New Brunswick, but not in Alberta, Saskatchewan, Manitoba, Quebec, Nova Scotia or Prince Edward Island. The MCC, it must be emphasized, can *register* but it cannot license; the latter power remains with the provinces.¹⁹ The benefits of standardization which the MCC affords have been realized because the provincial colleges of practice have chosen to accept its certification; but, as we shall see, it is the provincial colleges themselves who must approve both the eligibility of a candidate to sit for the MCC examination and the internship prior to registration. In 1934 the College of Physicians and Surgeons of Ontario discontinued its own examinations and accepted the MCC examinations in their stead as a condition of licensure. The establishment in 1968 of the Federation of Provincial Licensing Authorities promise a further coordination of provincial licensing policies. This body comprises two representatives from each of the provincial colleges of practice — it may possibly include non-voting representatives of the Royal College of Physicians and Surgeons and the MCC and is advisory only.

Since 1925 not only practice rights but also the use of the titles "Doctor", "Physician" and "Surgeon" have been restricted in Ontario: only those duly registered under the Medical Act or the Dentistry Act are authorized to use these titles as occupational designations in the field of health.²⁰

The above brief history summarizes the development of statutory licensing, but reveals little of the enforcement or of the *de facto* impediments to unqualified practice. In Britain, as noted, there has never been a ban on unqualified practice, and a few years after the imposition of the first restrictions in 1858, the English medical directories showed twice as many unqualified men as regular practitioners. Most states in the U.S.A. did ban unqualified practice, but enforcement proved so difficult that most policing has devolved to the AMA and the Federal Food and Drug Administration. In Canada, as we have seen, unqualified practice was proscribed in 1865, but as late as 1871 the *Canadian Lancet* reported that, while there were over 1,777 registered practitioners in Ontario, about 500 were practising in defiance of the law.²¹ Prosecution by the College of Physicians and Surgeons of Ontario under the Ontario Medical Act has been the means of enforcement.²²

Much more extensive accounts of the historical development of the medical profession in Ontario may be found in Chapter 3 of this Report and in the supplementary study of the evolution of Ontario's health legislation by Elizabeth MacNab, published separately by this Committee.²³

As we proceed to consider the educational and regulatory aspects of medicine in Canada, it is well to keep in mind the model of practice upon which they

¹⁹R.S.C. 1952, c. 129, s. 5(c).

²⁰The Medical Act of Ontario, R.S.O. 1960, c. 234, s. 53, as amended by R.S.O. 1962-63, c. 80, s. 4.

²¹H. E. MacDermot, *op. cit.*, p. 19.

²²The College prosecutes two or three cases a year for the illegal practice of medicine. The College claims that its efforts in this area are greatly hampered by the lack of a statutory definition of medicine.

²³Elizabeth MacNab, *op. cit.*

have been based — that of the independent general practitioner in solo practice. The transplantation of British traditions to a sparsely populated frontier society gave birth to this image, and the educational and regulatory systems both were influenced by it and subsequently reinforced it, even in the face of great social and technological change. Such a physician must be educated and licensed to practise, in at least a rudimentary way, all branches of medicine. Until very recently, despite the fact that it is carried on in the teaching hospital — a setting most unlike the traditional solo general practice — undergraduate education has held to this goal; and the granting of undifferentiated licences still reflects it.

Independent solo general practice, while still prevalent, is less and less the norm in modern medicine. The profession is undergoing rapid social and technological change, to which its educational and regulatory structures must respond. In the next section we shall discuss the nature of this change, and then, against the background of traditional forms and present realities, shall proceed to consider particular aspects of the profession. A wide variety of methods of practice and forms of organization now characterizes modern medicine.

Changing Role

With the rest of our highly technological society, the medical profession shares two central trends: one towards specialization, the other towards institutionalization — “big medicine” in the current cliché.²⁴ The modern doctor, unlike his pioneer ancestor, usually is no longer an isolated and independent practitioner, aspiring to apply to his patients virtually the full range of knowledge and techniques available to the medical profession. Today’s practitioner has bought competence at the price of breadth and independence. He depends upon society to provide the expensive facilities for his education and, insofar as it involves hospital and laboratory work, for his practice. He depends upon his peers for the content of education of which graduation from medical school merely represents “the end of the beginning”, and for services to his patient which lie beyond his competence to provide. He depends upon the professionals and auxiliary personnel to relieve him of some of the great burden of work which medical care entails. This dependence is formalized in institutional contexts — the medical school, the hospital, the health centre, the group practice.

The effects of these two trends in Canada as a whole and in Ontario are revealed in the following statistics: the number of general practitioners declined from 66.0 per cent of the total number of active civilian physicians in Canada in 1951 to 48.9 per cent in 1961, while the percentage of certified specialists rose in the same period from 27.0 to 37.3 per cent. The remainder are non-certified specialists, physicians limiting their practice to a particular field of medicine.²⁵ A

²⁴See J. W. Grove, *op. cit.*, Part One.

²⁵S. Judek, *Medical Manpower in Canada*, Royal Commission on Health Services, Queen’s Printer, Ottawa, 1964, p. 156.

Canadian Medical Association manpower census²⁶ indicated that in Canada, the number of specialists increased by 94.6 per cent between 1955 and 1965, while the number of general practitioners increased by only 4.1 per cent, the total number of physicians by 36 per cent, and the population by 18 per cent. In the past ten years Canada has certified more specialists every year than it has graduated new physicians from medical schools. The CMA reported in 1967 that 53 per cent of 7,700 responding practising physicians were general practitioners. The Ontario Medical Association estimated that the percentage of licensed physicians resident in Ontario possessing specialist qualifications rose from 10 per cent in 1950 to approximately 48 per cent in 1966.²⁷

Institutionalization of medicine in Ontario has meant chiefly the increasing importance of the hospital as the locus of medical care, where the complex and expensive diagnostic and therapeutic equipment and a variety of health personnel are available. The emergency department of the hospital is now assuming many of the functions of the general practitioner, albeit often by default when a general practitioner is not available to the patient. Moreover, as Kohn suggests with regard to recent Canadian experience, "The hospital has substantially replaced the patient's home as the place where the doctor sees his patients apart from his office". He reports that in 1962, 24.4 per cent of visits by G.P.'s, 45.8 per cent of those by specialists, and 60.5 per cent of those by consultants were made in the hospital.²⁸ The number of physicians employed by hospitals in Canada on a full-time or part-time basis increased by nearly 150 per cent from 1,800 in 1950 to 4,500 in 1961.²⁹

Another form of institutionalization, the so-called "group" practice, began in Canada in the western provinces in the 1920's. By 1967, the CMA could report a survey estimating, on the basis of a sample of 8,233 physicians, that 55 per cent of the practising physicians in Canada are engaged in solo practice, 14.0 per cent in "two-doctor" practice, and 31.0 per cent in "group" practice;³⁰ the corresponding figures for Ontario were 63.4 per cent in solo practice, 13.0 per cent in "two-doctor" practice, and 25.3 per cent in "group" practice.³¹ Judek reported that, in 1962, of a national sample of 7,751 active physicians, 67.2 per cent were self-employed, 18.9 per cent were in partnership, and 13.9 per cent were in "group" practice.³² The comparable figures for Ontario were 73.2 per cent, 15.6

²⁶R. L. Perkin, "Medical Manpower in General Practice", Medical Care Insurance and Medical Manpower, manuscripts of the Canadian Medical Association Conference, Montreal, Quebec, June 19-23, 1967, pp. 95-100.

²⁷Information submitted to the Committee on the Healing Arts, from the Ontario Medical Association and the Royal College of Physicians and Surgeons of Canada.

²⁸R. Kohn, *Emerging Patterns in Health Care*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1965, p. 33.

²⁹S. Judek, *op. cit.*, p. 190.

³⁰Reported in E. K. Lyon, "Easing the Physician's Work Load — Developing Patterns: Will Group Practice Help?", in CMA manuscripts, *op. cit.*, p. 255.

³¹*Survey of the Medical Profession in Ontario*; Tabular Summary, Research and Planning Branch, Ontario Department of Health, September 1968, Table XIII.

³²S. Judek, *op. cit.*, p. 145.

per cent, and 10.7 per cent respectively. It should be noted here that "group practice" is a general term which may mean many things. The definition of "group practice" is not universally agreed upon.³³ We will devote considerable attention to an analysis of and recommendations concerning "group" practice, in Chapter 29, though we use the term in a wider sense than those of the two studies cited in this paragraph.

Before tracing the further implications of these two trends towards specialization and institutionalization, it is necessary to consider other consequences of the great improvements in medical technology. It is now possible to cure and indeed to prevent many diseases once considered fatal; hence the role of medicine is no longer confined to the treatment of those in the acute state of disease. Preventive and rehabilitative medicine are now generally acknowledged to have assumed a much greater importance and effectiveness than in the past. In addition, burgeoning activity in both medical and social sciences has drawn attention to "the social context of medicine", to the medical importance of social considerations such as the patient's relationship to his family and to the community as a whole.

The concept of "comprehensive health care", including "health medicine" as well as disease-oriented medicine, is becoming increasingly popular. But, although the medical technology to supply such care exists, few members of modern communities enjoy its benefits. In particular, preventive medical procedures are too often neglected. This is not the fault of individual practitioners; most first-contact physicians are already overworked in providing curative services. It is the fault rather of a health system in which medical schools have failed to emphasize preventive health (indeed, some have consigned preventive medicine largely to schools of hygiene organized separately from the medical faculty), and in which the rewards, in income and professional status, are relatively lower for this type of work than for other aspects of medical practice. Furthermore, and perhaps most importantly, the system is ill-organized for the provision of "comprehensive health care", including preventive medicine. The necessary technology is now divided among poorly coordinated groupings of practitioners and agencies, specialists, general practitioners, hospitals, community services, and public health agencies. Furthermore, concern with environmental health and social welfare schemes has drawn governmental agencies into the complex. As Magraw has said:

We make a mistake when we talk about problems of specialization in medicine. Our real problems are those of coordination and integration.³⁴

The institutionalization of medical care in hospitals and group practices has been one response to the need for integration. There have been others as well. First, there have been attempts to train a "new generalist" (a physician with post-graduate training in "family medicine") to replace the overworked and disappearing general practitioner in performing the coordinating role in health care delivery.

³³We presume that the CMA study used the term as defined in Canadian Medical Association, *Group Practice in Canada*, 1967, p. 8. For Judek's usage see S. Judek, *op. cit.*, pp. 204 ff.

³⁴Richard Magraw, *Ferment in Medicine*, W. B. Saunders, Philadelphia, 1966, p. 154.

Second, American experiments have sought to integrate not only medical personnel but paramedical personnel and members of other "health-related professions" as well. Undoubtedly, all of these attempts have merit, and each may be appropriate to different regions or different sectors within communities. Third, another means of integrating community health facilities is the multi-professional community health centre, administered by a local board or agency. Experiments in the United States in which embryo community health centres of this type have been established in low-income areas under the auspices of the Office of Economic Opportunity have exemplified such integrated patterns of practice in these settings. With only very few exceptions, community health centres of this type are not part of the Ontario scene (although multi-specialty group practices of physicians are more common). These patterns have considerable relevance for Canadian medicine and will be dealt with more extensively in Chapter 29.

Any discussion of institutionalization, including the trends towards combined or group practice of medicine, inevitably raises considerations of the relations between physicians and other health professions and disciplines. This Committee has received much evidence concerning strains or tensions between the medical profession and various other health practitioners. Repeatedly it has been suggested that the medical profession may misunderstand or neglect the interests of non-medical groups within the healing arts and dominate unduly its sister professions and other supplementary health personnel. We will have many observations and recommendations to make on this subject throughout our Report. At the outset, however, we wish to emphasize that while we see the physician as the natural leader or captain of the health team, we are conscious of the need to reduce misunderstandings and conflicts between the physician and other important health practitioners with whom he must work harmoniously. We recognize an important distinction between medical leadership and medical domination. There can be little doubt that on occasion the medical profession has been, or more important has appeared to be, overbearing in its relations with its colleagues from other disciplines and professions. The leader of a team cannot be an autocrat; indeed he can be most effective only when he earns the respect and wholehearted cooperation of his colleagues. Our recommendations throughout this Report are designed to bring about a situation in which not only the power but also the heavy responsibilities of the physician as leader of the team are recognized for the benefit of the entire health delivery system. Thus our emphasis upon the importance of the medical profession and the crucial role of the physician should not be interpreted as denigrating other related non-medical disciplines or as neglectful of their important contributions to health care. In short, a smoothly functioning health system requires that the central role of the physician be seen in the context of a coordinated health team.

We add that we are aware that a single form of organization may not be appropriate for all parts of the province or for all circumstances. The appropriate groupings of personnel may vary from a very simple to a highly complex form.

Medical Manpower and Recruitment

Manpower Supply

This Committee has not considered studies of current and future manpower requirements, or prescriptions of the means of meeting these requirements, as lying within its terms of reference — such studies had already been done for Canada by the Royal Commission on Health Services. Further, the undertaking of extensive manpower studies with the rigour that would make them useful would have absorbed all our energies. In addition, as we urge strongly in Chapter 24, manpower planning cannot be an intermittent process; it must be continuous and unrelenting.

But we believe that the case for the establishment of a sixth medical school in Ontario is sufficiently strong, without a detailed analysis, that we can recommend the immediate creation of a new school. We are not in a position to say that no more than one new medical school should be established, but the justification of such further additional schools would have to lie in a more refined analysis than we have attempted. Our limited purpose here is simply to indicate that all available evidence does point to the desirability of augmenting the supply of physicians educated in Ontario.

The concept of a “shortage” of health professionals, as well as the extreme difficulties of measuring manpower scarcities, have already been discussed in Chapter 5. There it is shown that neither the demand for physicians’ services nor even the supply through the educational system are determined primarily by market forces, but both are “administered” — that is to say, determined primarily by public policy.

In the briefest terms, the demand for health services is now determined by social choice which takes account of what is considered to be the level of social needs and the level of costs of services. The introduction of publicly financed health insurance is a reflection of the desire of the people of Ontario to make the quantity of health care available a matter of social choice, and this is only the culmination of a long trend towards providing insurance coverage for health services. The *Report of the Royal Commission on Health Services* makes it clear that public health insurance programs are intended to meet high and gradually rising demands for health care. The implications of the introduction of the Ontario Health Services Insurance Plan (OHSIP) for the demand for medical services are substantial. The creation of OHSIP indicates a growing public concern for the health of both individuals and the community, as well as a conviction that with rising levels of income and insurance coverage, increased quantities of services can be usefully absorbed by the community. Moreover, advances in medical technology enable physicians to cure an ever-increasing range of illness; this to some extent helps to generate additional demands for medical services. Further, the very success of medicine means the survival of many people who require much attention in later life. Thus we may assume that the demand for physicians’ services will continue to be strong in the foreseeable future.

Whether the number of trained physicians available will be able to meet this demand is problematic. At the present time, the predominating factors determining the supply of medical manpower are the numbers of educational places available for students in the medical schools of Ontario, and numbers of practitioners from other jurisdictions who move to Ontario and obtain licences to practise here. There can be no doubt that the quantity of resources devoted to medical education is a matter of public choice. It is also through public choice that the College of Physicians and Surgeons has the power to license immigrant physicians. The public insists upon the maintenance of high standards of medical services, and surveillance of the competence of physicians traditionally has been entrusted to the professional licensing body. Subject to our recommendations later in this chapter concerning the role of the medical schools in assuring competence of Canadian graduates, the College of Physicians and Surgeons is enabled, indeed expected, to place certain minimal restrictions on the supply of medical manpower by virtue of the licensing authority delegated to it by the Legislature. Thus, limitations on the supply of physicians' manpower are principally of the community's own making. They arise, for the most part, from the public's desire to establish and maintain minimum standards of quality.

There exists at least a potential danger that any body possessing economic monopoly powers may tend to restrict supply and keep prices high. We comment later (in this chapter, and in Chapter 25) on the implications of granting monopoly licensing powers to professional bodies, and on the desirability of establishing some form of public surveillance over, and public membership upon, licensing authorities. We regard these issues as important.

But for our limited purposes here concerning the supply of medical manpower, the question is, how can the community determine what quantity of services of a given quality "ought" to be available to meet social needs? Our analysis in Chapter 5 led us to conclude that there are only two possible methods to determine the "correct" quantity of a service which ought to be produced; the first method is market determination through the interplay of supply and demand, and the second is by deliberate specification and community choice. Having created a situation in the health sector in which the market is prevented from operating to produce the socially optimum supply and price of services automatically, we have to arrive at our decisions by other means. In the present state of our social and economic knowledge, the criteria for "adequacy" of a public service must be arbitrary; there are no precise means of measuring the optimal quantity of the service which "ought" to be available.

Therefore, in considering the adequacy of physicians' or other health professions' manpower supply, we are thrown back upon judgments which are to a considerable extent subjective. Orthodox economic market analysis is irrelevant because, through public policy, we have deliberately created a situation in which both supply and demand are administered. Supply is determined largely by considerations of quality of standards and the quantity of resources which the Province

is prepared to devote to medical education; demand is determined largely by public programs of health insurance which provide consumers with access to physicians' services without being subject to market restraints. In other words, medical services are not rationed by price. Measurements of "scarcity" must be subjective.

A simple example of such an arbitrary measure of the "adequacy" of our present supply of physicians is provided by the physician:population ratio, and comparisons of this ratio geographically and over time.³⁵ Thus, we could say that, from one point of view, the crude physician:population ratio in Ontario presently offers some evidence of a relatively satisfactory supply of physicians' services, because measures of population per physician in Ontario since 1941 show that the number of physicians has increased more rapidly than the growth of total population. The physician:population ratio in Ontario has risen from 1:903 in 1941 to 1:770 in 1968, as is shown in Table 8.1. However, if we look at the physician:population ratio in other countries, our conclusions are different. Table 8.2 indicates Canada's physician:population ratio as of 1966 in relation to other selected industrialized countries.

The shortcomings of simple physician:population ratios for projecting manpower requirements are well known.³⁶ Requirements for physicians in the future will depend not only on the total population; they will depend also on a host of other circumstances, such as the age structure of the population, the degree of

TABLE 8.1
The Physician:Population Ratio in Ontario, 1921-1968
(Census June 1921-1951; December 31, 1961-1967)

Year	No. of physicians (June)	Population (June)	Ratio
1921	3,459	2,934,000	848
1931	3,934	3,432,000	872
1941	4,195	3,788,000	903
1951	5,365	4,598,000	857
	(December)	(December)	
1961	8,136	6,298,000	774
1962	8,236	6,427,000	780
1963	8,478	6,568,000	775
1964	8,688	6,723,000	778
1965	8,702	6,888,000	792
1966	8,932	7,078,000	792
1967	9,110	7,240,000	795
1968	9,502	7,321,000	770

SOURCE: See Vol. 1, Chapter 6, Table 6.6.

³⁵See J. W. Grove, *op. cit.*, pp. 244 ff., and pp. 262 ff. for discussion of the use of other physician:population ratios.

³⁶*Ibid.*

TABLE 8.2
Number of Physicians, Population and Population per Physician
in Selected Countries, 1966 and 1967, as Indicated

Country	Year	Number of physicians	Population (000's)	Population per physician
Canada	1966	23,353	20,551	880
Ontario	1966	8,932	7,078	792
Sweden	1966	8,840	7,780	880
Finland	1967	3,956	4,668	1,180
Norway	66/67	4,847	3,781	780
United States	1967	305,453	198,544	650
Britain (England and Wales)	1967	56,500	48,590	860
France	1967	58,300	50,338	860
Netherlands	1966	14,550	12,513	860
Japan	1966	108,290	98,544	910
Switzerland	1967	9,066	6,074	670
Israel	1967	6,312	2,651	420
New Zealand	1966	3,270	2,681	820

SOURCE: *World Health Statistics Report*, Vol. 22, No. 3, 1969, pp. 172-180; Ontario figures from Table 8.1.

urbanization, the incidence of occupational hazards that may be yet to emerge, and increases of demand by the general public as incomes rise. Further changes in medical knowledge and technology, on the one hand, may increase the demand for physicians' services by making it possible to treat some illnesses that now are untreatable; on the other hand, they may reduce the number of physicians required if medical productivity is increased, if some contagious disease is eliminated, or if the incidence of some widespread malady is reduced. Nor do physician:population ratios disclose regional imbalances in the supply of physicians which leave rural areas with small numbers of them. These regional imbalances are documented in Judek³⁷ for 1962; in our own Table 6.4³⁸ for 1961; and in Fraser³⁹ for 1951, 1961 and 1966. The same sources also show specialists more heavily concentrated in urban areas than are general practitioners. The physician:population ratio also neglects the number of physicians who are engaged primarily in administration, teaching and research rather than in direct patient care. The Ontario Medical Association estimated in 1966 that only 54.1 per cent of all physicians in Ontario are available for first-contact care, the rest being engaged in consultantships, residencies, teaching, the insurance and drug industries, government employment and industrial medicine. Predictably, this situation was more pronounced in urban

³⁷S. Judek, *op. cit.*, pp. 131 ff.

³⁸This report Vol. 1, Chapter 6, Table 6.4.

³⁹R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, pp. 24 ff., Tables A224 to A248.

areas. In "northern and rural" areas, 66.4 per cent to 74.5 per cent of the doctors were seeing patients without referral. In Metropolitan Toronto this figure was 44.2 per cent, with 22.2 per cent seeing patients on referral, 23.5 per cent engaged in institutional practice, 1.7 per cent in public health work, and the remainder in non-clinical practice.⁴⁰

Because simple measures of physician:population ratios are only approximate measures of the adequacy of medical manpower, quantification of the number of physicians required to meet the province's needs must contain many elements of judgment. Even in the absence of sophisticated manpower studies, however, there are other indications that the demand for physicians' services may be outstripping the supply. Although the evidence may or may not indicate conclusively that a general "shortage" of physicians exists now, it does lead us to conclude that there will be a problem of "scarcity" in the future, unless expansion of our facilities for medical education is undertaken.

As for the present, there are many rural and northern communities which now lack the services of a resident physician;⁴¹ even in major urban areas some patients experience difficulty in obtaining the services of a family physician. The waiting time for an appointment with a physician in some areas appears to be lengthening, and the most common complaint of physicians themselves is of long hours and extreme overwork as they attempt to meet the mounting demands of patients. The Ontario Medical Association acknowledges that there are "insufficient" numbers of physicians in this province to meet current demands.⁴² Moreover, as we have indicated earlier in Chapter 7, utilization figures of hospital emergency and outpatient departments strongly suggest the difficulty experienced by many citizens in obtaining medical care on short notice and the heightened demand for medical services which cannot normally be filled by existing numbers of practitioners. In Toronto, the Toronto Academy of Medicine announced in December of 1967 that it was experiencing great difficulty in referring patients to general practitioners for emergency treatment, and decided to withdraw its "locate-a-doctor" emergency service advertisement from the Yellow Pages of the telephone directory. The executive secretary of the Toronto Academy was reported as saying that the shortage of general practitioners had "reduced the effectiveness of the service to the point where only six or seven of 400 to 500 calls a month can be placed".⁴³

For the future, there are four principal reasons why we believe that the supply of domestically educated medical manpower must be increased. The first of these reasons is the very heavy reliance which this province has placed upon foreign medical graduates to provide physicians' services in recent years. Over the period 1951-1966, nearly 30 per cent of the physicians licensed in Ontario received their

⁴⁰Ontario Medical Association, Brief to the Committee on the Healing Arts, 1967, pp. 39-40.

⁴¹See J. W. Grove, *op. cit.*, pp. 246 ff.

⁴²Ontario Medical Association, Brief to the Committee on the Healing Arts. 1967, pp. 27 and 29.

⁴³*Toronto Star*, December 11, 1967.

medical education outside Canada,⁴⁴ and since 1966 Ontario has become increasingly dependent upon immigrant physicians. In 1967, only 285 (47 per cent) of the 598 physicians added to Ontario's Register were educated in this province, and in 1968 only 278 (42 per cent) of our 668 newly registered physicians were graduates of our own medical schools.⁴⁵ Without the large inflow of skilled personnel from other provinces and from other countries, our supply of medical manpower would have been sharply lower than it is.

Certainly we have no wish to discourage the mobility of professional personnel or to place undue restrictions on the ability of qualified foreign physicians to be licensed in Ontario. While it is appropriate that during periods of heavy immigration a significant number of foreign medical graduates should also enter the province, we believe that it would be unwise to continue to rely upon physicians from abroad, or even from other provinces, for so large a percentage of our medical manpower as we have done in recent years. Foreign sources of medical manpower could be diminished at any time by external forces beyond this province's control. Therefore, we are convinced that in the long run it is unrealistic to rely as heavily upon sustained importation of socially necessary professional skills as Ontario has done during the past decade. This affluent province can and should be capable of educating a larger number of physicians than it has in the past.

The second basic reason for our desire to augment Ontario's medical educational facilities is that it is impossible to predict any surplus of physicians in this province in the foreseeable future. We are aware of the projections made by the Department of Health and the substantial increase expected in the numbers of graduates from our medical schools during the next decade, but in our opinion these anticipated numbers of graduates will not alone suffice to meet future needs. Granted the shortcomings of the physician:population ratio as an absolute indicator of adequacy of physicians' manpower, and given the planned expansion of our medical schools which is already under way, and even allowing for significant numbers of foreign-trained physicians entering the province, our physician:population ratio (while we expect it to improve) will still fall short of the ratio in leading industrialized western nations during the coming decades.

Third, later in this chapter we recommend that the medical schools assume the responsibility for providing continuing education for physicians. We realize that this task will require substantial expansion⁴⁶ on the part of the medical schools, but we believe it most important. A sixth medical school can contribute towards continuing education both by increasing total medical school capacity and by adding a new geographical centre of education.

Finally, although the province has already announced its intention to create a new medical school, we recognize that at least a decade is required from the time

⁴⁴J. W. Grove, *op. cit.*, p. 116.

⁴⁵See Chapter 6, Table 6.8.

⁴⁶College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, July 5, 1967, pp. 5636 ff.

a medical school is projected until its first graduates are available for patient care. Thus the time lag between planning and achievement makes it necessary that the province should proceed with the creation of a sixth medical school with all reasonable dispatch.

Recommendation:

- 1 That the sixth medical school planned for Ontario should be established immediately in order to assist in providing the increased numbers of physicians required by the province.

At least until the recent past, health manpower planning has proceeded upon inadequate statistical information concerning Ontario's needs. Even now, we do not know of any sophisticated study that has attempted to take account of the factors affecting the demand for physicians which we have noted so briefly and incompletely. In the future, we propose (see Chapter 24) that the fulfilment of medical and other health manpower needs should be the subject of careful and continuous review and forward planning by public authorities.

Recommendation:

- 2 That there be an increased emphasis on medical and other health manpower planning, and that studies of manpower requirements should be conducted continuously by both the Ontario Council of Health and the Research and Planning Branch of the Department of Health.

Recruitment

If the output of our medical schools is to be increased, it is important that we consider as well the process whereby places in medical schools are filled. Control over entry to the profession begins, of course, with the admissions committees of the medical schools. Because of the limited number of places in the medical schools now, the pool of potential medical manpower is not being fully tapped. There are conflicts of opinion, however, about how large this pool is.

The academic standards for admission will be discussed below, but there is much more to be known about the keys to this portal of the profession. A study currently being carried out by the Association of Canadian Medical Colleges (ACMC) has produced for 1967-1968 the figures shown in Table 8.3.

The marked degree to which Ontario medical schools fill their first-year places with Ontario applicants is an indication of the pressure to enter medical schools on Ontario residents. The University of Toronto admissions policy gives definite preference to Ontario residents for admission to the Faculty of Medicine.

In conducting the above study, the ACMC also asked each medical school to assign each applicant a rating of "acceptable", "marginally acceptable", or "not acceptable", according to the school's standards, whether or not space permitted the applicant actually to be accepted. Sixty-one (7.0 per cent) of the Canadian applicants received "acceptable" ratings from each school to which they applied,

TABLE 8.3
Total First Year Places, and Applicants Accepted and Registered
in Ontario Medical Schools, 1967-1968

University	Total first-year places		Places occupied by registered premed. students and repeaters		Ontario applicants accepted and registered		Other Canadian applicants accepted and registered		Foreign applicants accepted and registered	
	No.	%	No.	%	No.	%	No.	%	No.	%
Toronto	164	100	112	68.3	34	20.7	9	5.5	9	5.5
Queen's	70	100	51	72.9	8	11.4	5	7.1	6	8.6
Western										
Ontario	76	100	0	0	72	94.7	0	0	4	5.3
Ottawa	77	100	51	66.2	15	19.5	7	9.1	4	5.3

SOURCE: R. Nelson-Jones and D. G. Fish, "Canadian Applicants to Canadian Medical Schools for 1967-68", *Canadian Medical Association Journal*, Vol. 99, No. 13, October 5, 1968, p. 655, Table 1.

but were accepted nowhere, while sixty-eight applicants received at least one "acceptable" rating but gained no admission. The authors concluded that "there seems to be a possibility of wastage of potential medical school resources". They further note that the first figure has grown from sixteen in 1965-1966, to thirty-six in 1966-1967, to sixty-one for 1967-1968, and speculate that had landed immigrants been included, the total would have been higher.⁴⁷ However, in the face of the finding that 27 per cent of the Canadians who were accepted and registered at medical schools received evaluations other than acceptable, the overriding conclusion of the ACMC study was that "Canadian medical schools are still experiencing difficulty in attracting well-qualified applicants for study in medicine".⁴⁸ This is consistent with an earlier (1967) finding by the same group which "contradict(ed) the popularly held view that Canadian medical schools are turning down well-qualified applicants".⁴⁹ But there must be many reservations to this position, some of which have been indicated. The finding is also somewhat weakened by the increase from thirty-six to sixty-one of rejected "acceptables" from the one study to the other. The findings of both studies, however, are subject to Grove's criticism of the 1967 finding quoted above:

. . . . It may be said, with respect, that it *may* do so (i.e., contradict the popularly held view . . . etc.): whether it *actually* does turns on what the standards of acceptability in the various schools are and how they differ from school to school. These are big questions, the answers to which might well affect the validity of the authors' conclusions at several points . . . it may be true that the different interpretations of acceptability are little related

⁴⁷R. Nelson-Jones and D. G. Fish, "Canadian Applicants to Canadian Medical Schools for 1967-68", *Canadian Medical Association Journal*, Vol. 99, No. 13, October 5, 1968, p. 658.

⁴⁸*Ibid.*, p. 660.

⁴⁹G. G. Clarke and D. G. Fish, "Applicants to Canadian Medical Schools for 1966-67", *Canadian Medical Association Journal*, Vol. 96, April 1, 1967, p. 927.

to differences in the *academic* standards demanded, but that is hardly the point. It is not academic standards that are in question so much as how the schools go about interpreting "personal characteristics such as age . . ." and so forth. It is in this realm that most of the "rumours and folk-lore" persist, and it is precisely here that we most lack hard facts.⁵⁰

It is to be hoped that more "hard facts" will be forthcoming from the APMC studies in the form of breakdowns of their valuable data by age, sex, ethnicity, and the like. There is a need for further studies, both of the motives that lead young people to take up medicine, and of the conditions that inhibit them from doing so, as well as the practices and principles that guide the medical schools in their admission policies. There is also a need for energetic measures on the part of the provincial government and the profession to improve the present situation.

We note the neglect of the total pool of potential medical manpower resulting from the traditional policy of restricting medical school admissions to those with educational backgrounds in the natural and biological sciences; the current admissions policy at McMaster University, employing a broader base of recruitment, seems much more satisfactory. (This point is elaborated in the section on medical education which follows.) We urge that admission officers continue and expand their present efforts to develop methods of evaluation which will reduce reliance upon academic grades as criteria for admission, and produce a broader basis for evaluating the individual's potential as a medical student and as a physician.

We note, further, that the number of women accepted as students in Ontario's medical schools, while growing, remains low. If it were known that the numbers of places open to women were larger, the numbers of acceptable applicants no doubt would increase. A recent study of women in family practice suggested the important role to be played by women in this important and understaffed area, stressing the contribution and interest of women physicians in such aspects of medicine as the care of women patients and children, preventive medicine, and dealing with emotional and family problems.⁵¹ Grove's study also provides suggestive evidence of the various ways in which informal but effective social barriers are erected to discourage greater utilization of female skills in medicine.⁵² Neither the medical aptitude possessed by members of this segment of the population, nor the medical skills of those women already trained, is adequately exploited. A 1967-1968 study by the Association of Canadian Medical Colleges revealed that 12.7 per cent of applicants to Canadian medical schools and 14.4 per cent of those accepted were female, a finding which suggests a slightly higher degree of success for female than for male applicants.⁵³ It is necessary, however, to question why the percentage of female applicants is so low. Why are women apparently

⁵⁰J. W. Grove, *op. cit.*, p. 105.

⁵¹Marilyn Trenholme, "Women Doctors in Family Practice", *Canadian Family Physician*, September 1967, pp. 45-55, and October 1967, pp. 37-44.

⁵²J. W. Grove, *op. cit.*, pp. 263-267.

⁵³R. Nelson-Jones and D. G. Fish, *op. cit.*, p. 657.

deterred from making applications to medical schools? Some of the reasons may be obvious, but some are less so. Most of the latter reasons appear to bear some relation to working conditions.

If recruitment from this source is to be increased, the conditions of medical practice must be made less onerous and more attractive to women by alleviating the problems unique to the female physician. Many of these problems involve the care of the female physician's own family. Improved facilities for coping with these family problems together with increased opportunities for part-time employment and for refresher courses after periods of absence from practice, may provide at least partial solutions to the problem of better utilization of women practitioners. A 1964 survey of Canadian women physicians revealed 73 per cent working full time, 6 per cent part time, and the rest were "retired" or "not in practice".⁵⁴ Although the figures are not strictly comparable, we note that a 1966 Ontario Medical Association survey of 5,046 of its members revealed only 7.5 per cent doing work which did not involve any patient care.⁵⁵ Since hospital emergency departments and group practices, among other institutions, offer increasing opportunities for the type of part-time work and/or regular hours more suitable for married women doctors, we feel that both an untapped pool of talent and the opportunities for its utilization exist here. Again quoting Grove:

It is not to be expected that efforts to encourage the employment of women doctors will make more than a token contribution to the immediate manpower situation; but it is surely folly, in modern conditions, when so much part-time work in other occupations is done by women, to waste even those resources that we have. Moreover, the knowledge that there exist greater and more rewarding opportunities for the married woman doctor, with adequate "refresher" training for her when her children are old enough to allow her to return and sufficient financial incentives to make such a return worthwhile, might well encourage more young women to enter the profession in the first place.⁵⁶

A program of refresher courses for retired or part-time women physicians was inaugurated in 1968. It was carried out by the Division of Post-Graduate Education of the University of Toronto in cooperation with the Ontario branch of the Federation of Medical Women of Canada. Twenty-seven women participated in the three-week course and expressed at least an initially favourable reaction. We understand that the sponsors intend to conduct the course on an annual basis and to collect follow-up data concerning the careers of the participants, a most constructive development.

In the light of the importance of this matter of recruitment, we make the following recommendation.

⁵⁴E. M. MacDonald and E. M. Webb, "A Survey of Women Physicians in Canada, 1883-1964", *Canadian Medical Association Journal*, Vol. 94, p. 1223.

⁵⁵Ontario Medical Association, Brief to the Committee on the Healing Arts, 1967, p. 39.

⁵⁶J. W. Grove, *op. cit.*, p. 267.

Recommendation:

- 3 That the Minister of Health of Ontario request that the Council of Deans of Ontario Faculties of Medicine ensure that information concerning applications for entrance to medical schools in Ontario be properly analyzed. Necessary steps should include elimination of duplication in count of applications; proper categorization of an applicant as being refused 1) on strictly academic grounds; 2) because the medical school's quota is filled; 3) on account of geographic or other considerations; 4) on account of sex. The Committee recommends the establishment of a centralized application procedure for medicine such as that now used for admission to most Arts and Science faculties in Ontario.

The financial cost of a medical education, together with a relatively short summer earning period, undoubtedly deters many prospective students from embarking upon medical studies. In the light of the recently published finding of the ACMC⁵⁷ that disproportionate numbers of Canadian medical students come from upper-middle class (professional and managerial) families (60 per cent as opposed to 20 per cent in the total labour force), we suggest that recruitment from underrepresented groups be made through the provision of adequate financial aid. We realize that this is only one factor affecting attendance at medical schools, but it is still a factor.

Until recently, the only bursary aid available to undergraduate medical students from the Ontario Department of Health was in the form of conditional bursaries of \$1,500 per year for single students and \$2,000 per year for married students. In 1969, however, the Department increased the bursaries to \$3,000 per year, not differentiating between married and single students. At the time they receive this aid, the students are required to sign a pledge to practise in one of several communities with acute physician shortages for one year for each annual bursary received. However, some students have chosen at graduation to pay back these bursaries so that they may be free to practise in larger centres. All applications for such aid have been granted. The relevant figures for the last four years are given in Table 8.4, and it is noteworthy that the increase in the amount of the bursaries resulted in a marked increase in applicants.

TABLE 8.4
Conditional Bursary Aid Taken Up by Ontario Medical Students

1966-1967	1967-1968	1968-1969	1969-1970
8 at \$1,000	8 at \$2,000 3 at \$1,500	7 at \$2,000	65 at \$3,000 (interim)

SOURCE: Information obtained from the Ontario Department of Health.

⁵⁷D. G. Fish, C. Farmer, and R. Nelson-Jones, "Some Characteristics of Students in Canadian Medical Schools, 1965-66", *Canadian Medical Association Journal*, November 16, 1968, Vol. 99, No. 19, pp. 950-954.

Bursary aid is also available to a limited degree from other sources — the Medical Alumni Association of the University of Toronto, for example. Furthermore, it has been estimated that approximately one-quarter of medical students receive loans ranging up to \$600 per year under the Province of Ontario Student Aid Program. A study done for the British Royal Commission on Medical Education estimated that 9 per cent of the Canadian medical undergraduates' income was in the form of loans.⁵⁸

The Department of Health has announced that starting in the summer of 1970 it will make bursaries of \$1,200 (\$400 per month for the three summer months) available for medical students who will serve a preceptorship with a general practitioner in Ontario. The preceptor will be chosen by the College of Family Physicians who is cooperating with the Department of Health in the organization and administration of the program. As well as providing employment for medical students, the program is designed to encourage interest in general practice as a career. The Department expects that twenty preceptorships will be available during the first summer, and the program is open to medical students following the first, second and third academic years.

However, many medical students without adequate parental financial support will still be forced to take up summer employment in fields unrelated to their careers. In order to reduce this necessity and hence to accelerate somewhat the student's progress through medical school, and to reduce financial restrictions on access to medical education, we propose that assistance also be made available to enable students to work in hospitals and other health service institutions during the summer.

Recommendation:

- 4 That the Province of Ontario provide financial assistance to medical students to enable them to work in hospitals or other health service institutions during the summer.

Education

As indicated earlier in this chapter, responsibility for medical education today in Ontario, as throughout Canada, is neither continuous nor uniform. The course of studies divides into premedical, professional and graduate, or postgraduate studies, each carried out under a different mix of institutions and regulatory agencies. In general, premedical education, whether or not it is explicitly recognized as leading to professional training, is conducted by the Faculty of Arts and Science of the university; the four "professional" years of education are under the control of the Faculty of Medicine: the internship year, prior to licensure, is conducted in and directed by the individual accredited hospitals, although it is coming

⁵⁸Reported in Stuart McClure, "Financing of Students' Grants or Loans?" *British Medical Journal*, January 21, 1967, p. 167.

increasingly under the control of the medical schools. Graduate and postgraduate training are under the auspices and control, to varying degrees, of the universities, the hospital, and the Royal College of Physicians and Surgeons of Canada.

Premedical Education

Two of the five Ontario universities having medical faculties offer a specifically "premedical" course — University of Ottawa and Queen's University. The course consists of two years of study in the basic medical sciences (and increasingly in the behavioural sciences), with electives in the humanities and social sciences. The courses are conducted in and by the Faculty of Arts and Science; however, students are admitted to the premedical course by the Faculty of Medicine. Admission is based on high school academic standing. Until 1969, the University of Toronto also offered such a "premedical" course. The last students to be enrolled in this course will complete it in the spring of 1970.

As will become evident below in the discussion of admission standards, the formal premedical course is only one of the types of training which might precede the four professional years.

Professional Years

In 1969-1970, five universities in Ontario offered programs leading to the M.D. degree — University of Toronto; Queen's University, Kingston; University of Western Ontario, London; University of Ottawa; and McMaster University, Hamilton. The Faculty of Medicine at McMaster admitted its first undergraduate students in 1969.

Admissions

Admission standards to the four-year professional course leading to the M.D. degree vary among the five faculties of medicine, but the minimum requirements prescribed by the College of Physicians and Surgeons of Ontario, in accord with its statutory responsibility, are as follows:

Either senior matriculation, including courses in mathematics and sciences and a minimum of two years of study at an approved university, including two full courses in chemistry and at least one full course in each of biology and physics;

OR

A degree in arts or science from a college or university approved by the College of Physicians and Surgeons of Ontario.

These requirements are *only* a minimum; each of the medical schools has erected additional qualifications upon this basic floor. (We shall comment further upon this requirement below, page 67).

The two-year premedical courses, noted above, constitute one route of entry at Queen's and the University of Ottawa, and until recently at the University of

Toronto. Only Queen's, however, guarantees its premedical students entry to the first professional year provided they meet the pass requirements for premedicine; Ottawa requires that premedical students join the competitive pool of applicants for places in first year medicine. Other routes of entry include the possession of a B.A. or B.Sc. degree, provided certain course requirements have been fulfilled. McMaster, in fact, requires the possession of a B.A. from a recognized university or the completion of the first three years of an honours degree in the Faculty of Arts and Science. It intends to accept applicants with backgrounds not only in the natural and biological sciences, but in the social sciences and other disciplines as well. Admission is determined not by formal requirements, but by the judgment of an admission committee. The Universities of Toronto, Western Ontario and Queen's require applicants to write the Medical Colleges Admission Test (MCAT), administered by the Psychological Corporation of New York.

Auspices

The statutory responsibility for prescribing a curriculum of studies to be pursued by students in medical faculties in Ontario lies with the College of Physicians and Surgeons of Ontario. Now, however, the College leaves this function to the medical schools, which are subject to accreditation; but as just mentioned, the College continues to prescribe entrance requirements.

A considerable degree of standardization and coordination in medical education results from the fact that all Ontario medical schools (and most other medical schools in Canada) administer the examinations set by the Medical Council of Canada (MCC) as their final examinations, upon which the granting of the M.D. degree is contingent. The interplay and overlapping membership between the MCC and the medical faculties mean that the MCC examinations both reflect and shape the course content of the medical schools. Where the MCC tests are written as the final examinations of the medical school, the papers are graded first by the medical faculty of the school. Papers of candidates deemed successful in all subjects by the medical faculty are then forwarded to the MCC Board of Examiners for grading. An MCC representative also participates in the oral examinations in clinical subjects.

A further standardizing agency is the Association of Canadian Medical Colleges (the ACMC). Accreditation of all North American medical schools is performed by the Joint Accreditation Council of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association. The ACMC is represented on this body when it makes its accreditation surveys of Canadian medical schools at intervals of seven to ten years. The ACMC is also actively engaged in research concerning medical education in Canada.

In Ontario, the Council of Deans of Ontario Faculties of Medicine, formed in the 1960's, has facilitated an interchange of information and ideas among the province's medical schools.

Coordination is further enhanced by the considerable degree of overlapping membership among the MCC, the APMC, the faculties of medicine, and the Council of Deans of Ontario Faculties of Medicine. Each faculty of medicine enjoys statutory representation on the MCC; the APMC has as its members the deans of the faculties of medicine in Canada, and very often the same persons hold positions (although not simultaneously) on three or even all four bodies.

We have several reflections to make on this matter of responsibility for undergraduate education. The statutory responsibility of the College of Physicians and Surgeons to prescribe minimum admission and curriculum requirements was necessary and salutary when the development of a system of medical education was in its earlier stages, but has now become irrelevant. All schools exceed these requirements, and the maintenance of standards is ensured through associations of medical educators themselves, such as the Medical Council of Canada, the Association of Canadian Medical Colleges, the Council of Deans of Ontario Faculties of Medicine; and through the accrediting processes. We believe the continuation of the power in a regulatory body to prescribe admission requirements and curriculum to be unnecessary and even undesirable. We will elaborate upon this point in Chapters 25 and 26. The Committee believes there are other methods of assuring maintenance of standards of medical education, such as the association of medical educators noted above, and does not accept the view that regulatory bodies should continue to determine the education of future practitioners.

Recommendation:

- 5 That the Medical Act be amended to remove the power of the College of Physicians and Surgeons of Ontario to specify either minimum admission requirements or minimum curriculum for medical education.

We have heard some queries concerning the accreditation of Canadian medical schools by an American body, the suggestion being that this system may inhibit experimentation by Canadian schools. In the interest of maintaining international standards we are not persuaded that the time is yet ripe to end this arrangement, nor, indeed, that there is sufficient evidence that a change is necessary.

Recommendation:

- 6 That medical schools in Ontario should continue to be accredited by the Joint Accreditation Council of the Association of American Medical Colleges, and the Council on Medical Education and Hospitals of the American Medical Association, augmented, however, by representatives from the Association of Canadian Medical Colleges.

Affiliated with each of the medical faculties are numerous teaching hospitals in which the clinical aspects of the student's training are conducted. This affiliation intrudes another institution into the complex of responsibility for education, although the focus of responsibility is much clearer in the case of undergraduate than that of postgraduate education. In the former case responsibility for the education of students clearly lies with the faculty of medicine; but in the case of

postgraduate education, towards which much of the educational activity of the clinical departments of the hospitals is directed, the problems of divided responsibility consequently become more acute. The problems arising from the teaching hospital-medical school affiliation are best considered in Chapter 27 dealing with issues arising from our consideration of hospitals; here we merely note this important participant in the system of medical education.

Curricula

Until recently, the objective determining the undergraduate curriculum was the production of a graduate with a broad range of medical competence. The general format of the curriculum was to devote the first two years of the program to instruction in the "pre-clinical" sciences — anatomy, histology, biochemistry, physiology, pathology, bacteriology and pharmacology — with introduction to the "clinical" sciences, in the third and fourth years, exposing the student to each of the major clinical specialties, using both bedside and didactic techniques.

Now, however, the ideal end-product of the four years of professional training leading to the granting of the M.D. degree is the "basic physician" who will function only within a delimited area, but who will possess a "bird's eye view" of the broad field of medical knowledge to enable him to recognize and refer cases outside his area of competence to the appropriate colleague. Hence undergraduate training is coming to be regarded less as a preparation for practice than as a basis for further, more specialized training or, in the words of one calendar, "to provide the core of fundamental knowledge and technical skill which forms a basis for further graduate study leading to family practice, specialization, or research".⁵⁹

This general change in format is reflected in the following trends in curriculum revision.

First, increased time is being devoted to clinical subjects and clinical methods of teaching, with a corresponding decrease in the use of didactic methods. Queen's University, the University of Western Ontario and the University of Ottawa have for some time offered clinical clerkships of at least twenty-eight to thirty weeks' duration, involving rotation among the four blocks of medicine, surgery, obstetrics and paediatrics. As of June 1969, clinical clerkships, with little or no lecture time, will comprise the entire final year of the undergraduate program at Queen's University, the University of Toronto and the University of Western Ontario; the University of Ottawa will follow suit in 1970.

Second, the student is being exposed earlier to clinical methods. Queen's, the University of Toronto and the University of Western Ontario now introduce the student to the clinic in the second year.

Third, interdepartmental teaching programs, designed to integrate the basic "preclinical" and "clinical sciences" are being developed. Western has introduced

⁵⁹Faculty of Medicine, University of Western Ontario, London, Ontario, Eighty-Fifth Annual Announcement 1966-67, p. 42.

a combined course in the neurological sciences; Toronto is involved in an intensive investigation of the "systems teaching" method — this is the method of teaching developed originally at Western Reserve University whereby the material presented to the student is organized not as the discrete subjects of anatomy, biochemistry, neurology, physiology, and so on, but in terms of biological systems. Through this method, the anatomical, biochemical and histological aspects of biological systems are considered in an integrated manner.

Fourth, increased allotment of time is being given to electives. This development is as yet in an early stage and does not greatly alter the concept of the four professional years as providing a "common core" of knowledge.

Fifth, the distorted view of medical practice afforded the student who sees primarily patients in the acute stage of disease on hospital wards is being recognized and a corresponding increase in the time, including elective time, devoted to "family practice" involving social and preventive aspects of medical care is being allowed. Family practice units staffed by full-time general practitioners are now involved in undergraduate teaching at the Toronto General, Toronto Western, and Sunnybrook hospitals in Toronto, at the Kingston General Hospital in Kingston, and at the St. Joseph's Hospital in London.

The undergraduate curriculum at McMaster requires separate treatment, involving as it does the first departure in Ontario from the traditional format outlined above. Having made the entrance requirement to the professional course at least three, rather than two, years of university study, it has reduced the length of its professional program to 120-130 weeks. Those involved have expressed the hope that financial aid to students will be forthcoming to free students from the necessity of seeking summer employment. This would allow the program to be condensed into three calendar years, one devoted to "human biology", the remainder almost entirely to clinical study. Students who have entered the program, having completed three years of the McMaster honours program in biological or social and biological sciences will receive an honours Bachelor's degree after the first year, the "human biology" portion, of their professional course. A move in this direction has also been made at the University of Western Ontario, where students may take the first medical year as the third year of an honours program in one of the medical biological sciences, then complete the fourth year of the honours program to receive an honours B.Sc. degree, and subsequently continue their professional training in the second medical year. The medical faculty of the University of Toronto accepts students who have completed the four-year honours program in biological and medical sciences in the Faculty of Arts and Science into the second year of the professional course. Such moves as this, in combining a broadening of the educational background of the medical student with a concentration of his professional training, may eventually lead to a redefinition of the relationship between the university and its medical faculty, in which the former assumes greater responsibility for the general preparation of the student and the latter becomes even more professionally oriented.

These attempts on the part of Ontario medical schools to allow for flexibility in the undergraduate medical curriculum and to give it greater relevance to the future practice of the individual physician are progressive measures; but more remains to be done. Detailed proposals concerning the content of the undergraduate curriculum lie not only beyond our competence, but outside our terms of reference. We make, however, some comments on general principles.

The undergraduate medical curriculum is undergoing a thorough reappraisal in many countries. It is clear that in modern circumstances, four years of professional training can provide only a basic minimum medical education, and that, in the words of the British General Medical Council, "graduation has become neither the end of medical education nor the beginning of the end, but rather the end of the beginning".⁶⁰ The question of the content of a basic medical education is thus of paramount importance. The medical and basic science components, of course, can be determined only by those responsible for teaching and examining them, but even here there are certain principles on which we have some comments. For reasons discussed in Chapters 13 and 28, increased training in the recognition and treatment of the psychological aspects of illness is of great importance. Furthermore, it seems to us that the arguments for a greater place in the curriculum for some of the social sciences, such as social psychology and medical sociology, are strong. Medical training traditionally has been a very ingrown and "technical" affair. It is important that the medical student should be exposed, at what is an extremely formative period of his life, to other influences, and particularly to the insights of the social sciences that are most closely related to medical practice.⁶¹

Of relevance also to this discussion of the social context of medicine is the relative neglect of preventive medicine in the undergraduate curriculum, a neglect sometimes reflected in the consignment of instruction in preventive medical techniques to a "school of hygiene" or a separate division within the faculty of medicine. There is encouraging evidence of a redressing of these imbalances, however, in the McMaster curriculum and in the fact that the University of Toronto in 1969 announced the establishment of a department of preventive medicine as a joint responsibility of the Faculty of Medicine and the School of Hygiene.

Recommendation:

- 7 That greater emphasis upon social and preventive medicine and social sciences should be included in the undergraduate medical curriculum.

A second general principle on which we wish to comment is the increasing emphasis in undergraduate medical education on "research-oriented teaching". This is acknowledged to have certain undesirable consequences, which were touched

⁶⁰General Medical Council of the United Kingdom, *Recommendations as to Basic Medical Education*, 1967.

⁶¹J. W. Grove, *op. cit.*, Ch. 12.

upon in Grove's supporting study. He quotes an American physician's view that:

Research has become a sort of fetish and has acquired a status value. It is now considered chic to be "doing research" The so-called knowledge explosion has so fragmented knowledge that there is a real danger that the future will produce an ever-increasing number of specialized scientific hacks.⁶²

Grove further refers to the unofficial complaint of a member of the British Royal Commission on Medical Education, concerning the new climate of opinion in the medical schools that is "just as rigid and stereotyped as the old, in which only science, and only one kind of science, is recognized and all the other values in medicine are in danger of being lost or are played down in importance".⁶³

A related issue, and one of great importance, has been the relative neglect of general practice in the undergraduate curriculum. Although some students may participate in family practice units or in general practice preceptorships, most undergraduate clinical experience has occurred under specialist teachers on the wards of teaching hospitals. In Chapter 30 we shall comment at greater length upon the orientation for the recruitment and preparation of physicians for general practice; we merely draw attention to it here in the context of our discussion of the undergraduate curriculum.

Junior Internship

The completion of a one-year internship in a hospital (not necessarily a teaching hospital) to the satisfaction of the College of Physicians and Surgeons of Ontario is a condition of licensure in Ontario. A certificate of satisfactory internship issued by the College is required before the MCC will grant its licentiate, without which a physician cannot practise in Ontario.

Traditionally, the internship has involved rotation among various clinical departments of the hospital. The College until recently required that this rotation include at least one month on each of the services of medicine, surgery, obstetrics and paediatrics. It has been conducted entirely by the hospital concerned. Recently, this "junior rotating internship" has come under criticism as subjecting the young physician to considerable financial hardship and overwork⁶⁴ for the sake of acquiring a superficial acquaintance with fields of medicine of quite limited relevance to his ultimate practice. As long as the goal of undergraduate education was to produce a general practitioner, it was felt necessary to broaden the clinical experience of the young physician before allowing him to practise.

Two trends in medical education, however, are rendering the junior rotating internship an anachronistic and increasingly unnecessary prolongation of medical

⁶²J. A. Gengerelli, *Journal of the American Medical Association*, Vol. 193, 1965, p. 583, quoted in J. W. Grove, *op. cit.*, p. 219.

⁶³Sir Robert Platt, "Reflections on Medicine and Humanism", The Linacre Lecture for 1963, Royal College of Physicians of London, quoted in J. W. Grove, *op. cit.*, p. 218.

⁶⁴See for example, J. W. Grove, *op. cit.*, pp. 221ff.

education. The first of these trends, noted above, is the increase in clinical studies in the undergraduate years. The second is the tendency for the undergraduate period to become only a phase in a longer educational program culminating in certification or fellowship in a clinical specialty, or in a degree in a field of biomedical research. The suitability of a physician for "general practice" or "family medicine" upon completing the MCC licentiate is questioned, and the necessity of further education, as noted below, is strongly propounded. In such a situation, the junior internship as it has been appears obsolete. The Royal College of Physicians and Surgeons, however, still requires a year spent in junior internship as a qualification for sitting the certification and fellowship examinations. It modified its stand in 1967, however, to allow a straight rather than a rotating internship. In the same year the College of Physicians and Surgeons of Ontario began to accept a straight rather than a rotating junior internship prior to licensure if the new graduate were certified by his Dean of Medicine as having completed a satisfactory clinical clerkship. Given the widespread adoption of the clinical clerkship by Ontario medical schools, the effect of these moves by the College of Physicians and Surgeons of Ontario and the Royal College is to eliminate the junior rotating internship requirement, at least for those pursuing postgraduate training, making the first postgraduate year the first year of specialty training and thus shortening the total program by one year.

The College of Physicians and Surgeons of Ontario has gradually increased its control over junior interne training, as discussed in Grove's study.⁶⁵ All internes must be registered under the Medical Act—that is to say, their names must appear on the Educational Register. The College has, in principle, complete control of the type and location of the interne year. The policy of the College has been to accept the approval of the Committee on Interne Training of the Canadian Medical Association as the basis of its approval of internship programs. Recently the College has itself begun to make additional tours of inspection of CMA-approved internship programs in Ontario. It restricts its approval of American programs to those offered by university-affiliated hospitals. In 1969 it restricted this approval further to university-affiliated hospitals whose internship programs are approved by the AMA and which is approved for residency training in internal medicine, surgery, obstetrics and gynaecology, and paediatrics. Grove has noted the allegation by the Canadian Association of Medical Students and Internes that the College uses its influence to restrict the number of graduates interning in the United States.⁶⁶

We have heard several complaints concerning the junior internship, the most common of which allege the exploitation of the interne for service in the hospital, lack of coordination among the various segments of his program, and the great

⁶⁵See J. W. Grove, *op. cit.*, pp. 220ff, for a discussion of interne and residency programs.

⁶⁶*Ibid.*, p. 111.

disparity in the quality of internship programs across the province. We favour the increasing involvement of the schools of medicine in the internship program towards the end of making it an integrated educational experience.

Recommendation:

- 8 That the accreditation of hospitals for internship programs should be carried out on a national basis by the Association of Canadian Medical Colleges, but that if this is not possible, accreditation should be under the auspices of the Council of Deans of Ontario Faculties of Medicine. At the same time, the Committee recommends that medical schools should continue to control the internship experience as an integral part of the overall educational process.

We shall have more to say concerning the accreditation of facilities for internship programs after we have considered the more advanced stages of postgraduate medical education.

Graduate Programs

The distinction among "graduate", "postgraduate" and "continuing" education is not clear, but the most widely accepted definition appears to be one which sees 1) "graduate" education as full-time study after the M.D. leading to a degree, usually the M.Sc., Ph.D. or M.Cl.Sc.; 2) "postgraduate" education as full-time study after the M.D., leading not to a degree but usually either to a diploma or to a certification or fellowship in a specialty (the practice of including the junior internship under this appellation is not uniform); and 3) "continuing" education as part-time study in "refresher courses" for practising physicians.

Graduate studies involve research-oriented programs in the basic and clinical sciences, undertaken after completion of a B.A. or a B.Sc. degree, or their equivalent. Except in the case of the University of Ottawa, where they are offered by the Faculty of Medicine, these programs are offered under the aegis of the faculties of graduate studies of the universities. The length of the programs varies according to the undergraduate background of the student, and often according to the research project chosen, but the average length is one to two years for an M.Sc. and three to four years for a Ph.D. In the area of research in clinical sciences, Queen's Faculty of Graduate Studies and Ottawa's medical faculty offer an M.Sc. The University of Toronto's graduate school offers a Doctor of Clinical Science (D.Cl.Sc.) for a minimum of four years of research in a clinical science and a related basic science after an M.D. and one-year internship program. The graduate school of the University of Western Ontario offers an M.Cl.Sc. degree for a minimum of one year of research in a clinical science after the M.D. and internship program, and a Ph.D. program is offered in some clinical sciences as well. McMaster plans to offer, in its medical school and university hospital, graduate research programs leading to Master's and doctoral degrees; research and training facilities will be grouped into the three divisions of human biology, basic medical science and clinical sciences.

The faculties of medicine themselves offer postgraduate (i.e. non-degree) training leading to diplomas in certain clinical specialties.

Senior Internship and Residency Training

The problems of ambiguous responsibility and lack of coordination noted above have been the greatest at the level of senior internship and residency programs. Although this field of educational activity has been carried out largely in individual hospitals, teaching and non-teaching, neither the hospital nor the university awards recognition in the specialty in which residency training is undertaken. Rather, this is the function of the Royal College of Physicians and Surgeons of Canada, a national body which sets examinations in each of the specialties. Eligibility to sit for these examinations requires the possession of an M.D. degree from a medical school approved by the Royal College, plus the completion of a junior internship, a recommendation by the chief of the appropriate service, and the completion of three to five years (depending upon the specialty) of postgraduate training as a senior interne and resident. This period may include one year as a graduate student in basic science. At the end of the program the student may sit for examinations either for certification or for fellowship in the specialty. The standards for fellowship are higher than those for certification, and a candidate who fails to meet fellowship standards in the fellowship examination, by passing the written examination but failing to meet fellowship standards in the oral and clinical portions, may be recommended for certification. Additional training may be required of the candidate to bring himself up to fellowship standards. In an increasing number of specialties, including orthopaedic surgery, neurosurgery, cardiovascular and thoracic surgery, and neurology, only fellowship examinations are offered, and certificates in these specialties are not awarded.

Appointments to senior internships and residencies are made by the chief of the service concerned, and the programs are conducted by individual staff members. Even in teaching hospitals, there has been little involvement of the medical schools beyond that entailed in the joint hospital-university appointments of their staff. The necessary check upon the undue weighting of service objectives in educational programs may well be too weak in the cases of internships and residencies. A 1966 survey of a sample of residents in Canadian hospitals found this to be a common complaint:

Service responsibilities are frequently perceived by the resident as detrimental to his learning program, and, in fact, most residents interviewed reported that they felt that too many services were required of them. In particular they felt that greater use could be made of technicians, secretaries and other ancillary personnel and they expressed resentment that they may be required to do histories and discharge summaries for attending physicians with whose patients they have had little or no contact. It was generally agreed that the amount of "scut" work they performed was very much less than they had been required to do in their internship and junior

resident years. Nevertheless, as one resident put it, "we are cheap labour, there is no doubt about that", and most felt that there was still room for improvement.⁶⁷

Such feelings may be strong among foreign medical graduates, many of whom have practised in their native countries before coming to Canada, now training as internes and residents in Ontario hospitals in order to fulfil Ontario licensing requirements.⁶⁸ In 1968, of Ontario's 1,525 internes and residents, 57.2 per cent were graduates of Canadian medical schools; 13.7 per cent were from schools in the United Kingdom, Australia, New Zealand, South Africa and the United States; and 29.0 per cent were from other foreign schools. But while the number of Canadian graduates in internship and residency programs increased by only 2 per cent from 1967 to 1968, the number of graduates of non-Canadian schools in these positions showed a 21 per cent increase.⁶⁹ This situation leaves open the possibility of the charge, whether true or not, that the stringent licensing regulations for foreign medical graduates have the effect of creating a pool of labour for the hospitals. To maintain that this is a conscious policy is certainly to overstate the case, but it must be admitted that the present state of affairs carries this inherent danger. In any event, internships and residency programs should be regarded as educational experiences, and not primarily as service programs.

The hospital site of postgraduate medical education also has posed the problem of the lack of coordination of residency programs. At the individual level, this may make for a poorly integrated educational experience for the resident; the programs may consist of one-year blocks of training, each of which may be taken in a different hospital under a different chief.⁷⁰ At the broader social level, it may mean that the relative manpower supply in the various specialties is determined, at least in part, by the service requirements of individual hospitals and not by an overall assessment of community needs. These problems are now becoming somewhat less acute in teaching hospitals, where the medical school is coming to play an increasing role in the coordination of residency programs. At the University of Toronto, for example, the one-year segments of the program may be taken in different affiliated hospitals, but the rotations are arranged by the relevant department of the Faculty of Medicine and residents are appointed to hospital services on the recommendation of the university department concerned. The same university has taken a further step in this direction by establishing a central coordinating committee composed of representatives of the medical school and the teaching hospitals. The committee so far possesses no authority, and relies upon cooperation

⁶⁷D. G. Fish, "The Resident's View of Residency Training in Canada", *Canadian Medical Association Journal*, October 1, 1966, Vol. 95, p. 715.

⁶⁸See J. W. Grove, *op. cit.*, pp. 117 ff, for the conditions of licensing graduates of foreign medical schools.

⁶⁹College of Physicians and Surgeons of Ontario, *Report*, January 1969, p. 21.

⁷⁰See J. W. Grove, *op. cit.*, pp. 220ff. for a discussion of postgraduate training.

for the implementation of decisions taken.⁷¹ The Royal College of Physicians and Surgeons of Canada is making affiliation with a medical school a condition for its approval of hospital residency programs in an increasing number of specialties; it has announced that "by 1970 all one-year programs will be discontinued unless integrated under a medical school or teaching hospital".⁷²

The attitude of the Royal College of Physicians and Surgeons of Canada is a reflection of the growing body of opinion which sees the teaching hospital as the appropriate locus for *all* phases of medical education — undergraduate, internship and residency. Students at all stages of the educational process can benefit greatly from mutual association. Grove quotes the view of one medical educator that:

... a hospital must maintain a house staff of a certain minimum complexity if its members are to benefit properly from their work. Thus I would state categorically that an internship is not worth its salt unless the interne has associated with him throughout the year, not only a reasonable number of other internes, but also good assistant residents on the services through which he rotates. He will learn more from the assistant resident and from his fellow internes, if they are good men, than he will learn from the best and most conscientious attending staff.⁷³

Furthermore, the participation of the house staff of teaching hospitals in the training of those at earlier educational stages has beneficial "fall-out" for the staff themselves. In 1965, only 7 per cent of residents training in approved residency programs in Canada were in hospitals not affiliated with a medical school. Eighty-five per cent were training in hospitals with twenty or more residents. Figures for 1966-1967 show that 72.9 per cent of the internes training in Ontario were in teaching hospitals; 86.2 per cent enjoyed association with a resident staff of twenty or more.⁷⁴

The concentration of postgraduate training university-controlled programs in the teaching hospitals may eventually lead not only to more integrated educational programs, but also to the alleviation of one of the chief causes of complaint on the part of the house staff: their exploitation in the service of the hospital to the detriment of their educational experience.

It will be seen from what has appeared thus far that there are many accrediting programs for hospitals related to their role in medical education. For this purpose, there is hospital accreditation by the Joint Accreditation Council of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association, by the College of Physicians and Surgeons of Ontario, by the Royal College of Physicians and Surgeons of Canada,

⁷¹Faculty of Medicine, University of Toronto, reply to Questionnaire "C", Committee on the Healing Arts, Appendix B. This committee, of course, has functions far broader than the coordination of residency programs.

⁷²Jacques Turcot, President of the Royal College of Physicians and Surgeons of Canada, quoted in *Ontario Medical Review*, December 1968, p. 653.

⁷³D. L. Wilson, "The Place of Internships and Residencies in Medical Education", *Ontario Medical Review*, March 1964, quoted in J. W. Grove, *op. cit.*, p. 222.

⁷⁴Data derived from André Lalonde, "Bedlam Part 2", *Canadian Association of Medical Students and Internes Journal*, October 1967.

and by the Canadian Medical Association. In addition, there is the hospital accreditation for other than teaching purposes described in Chapter 27. The information required by the accrediting bodies and the related visits to the hospital by the accrediting teams take much time and effort on the part of those in hospitals. In order to reduce the multiplicity of demands on the hospitals for these purposes, and to take account of the reality of the interdependence of the programs, an effort should be made to coordinate the accrediting procedures as much as possible, at least to the extent of having accrediting teams standardize the required information as much as possible and to make visits at the same times.

Recommendation:

- 9 That, wherever possible, there should be coordination of accreditation programs, particularly with respect to coordination of accreditation of hospital facilities for purposes of medical education; and that the various agencies involved should arrange to carry out their accreditations simultaneously insofar as possible and develop standardized procedures where the same information is required by several agencies.

While we favour the increasing involvement of the universities in postgraduate education, we recognize the problems implicit in this trend. Confining this phase of education to the teaching hospital means, of course, either terminating some existing programs or bringing more programs within the aegis of the university. Given the sort of "town-gown" rivalry discussed in Chapter 27, it is apparent that the extension of university affiliation to a greater number of institutions may give rise to considerable conflict, not only between service-oriented hospital administrators and trustees on the one hand and education-oriented university officials on the other, but also between community-based physicians and their cross-appointed colleagues, particularly over such matters as access to beds. It is most desirable that methods be devised to obviate or mitigate this conflict. We hope that such studies as those currently being undertaken by the Association of Canadian Medical Colleges and the Coggeshall group at the University of Toronto (see Chapter 27) will facilitate the development of some solutions.

In discussing the extensions of university affiliation to a greater number of institutions we are brought to state our conviction that the range of health care institutions involved in medical education, as well as their number, must be extended. If the medical student is to see a representative sampling of patients throughout his training, it is essential that his experience not be confined to hospital wards. Extension of university-affiliated programs, especially internships and some residencies such as those in family practice (discussed below), to community-based group practices and health centres will provide the student with an opportunity to see patients at all stages along the continuum of health and disease within the context of an integrated educational program. We attach great importance to this matter, and shall return to it in later chapters.⁷⁵

⁷⁵See especially Chapter 29.

Recommendation:

- 10 That accreditation of facilities for internship and postgraduate medical education programs be extended to group practices and community health centres, but that these programs remain under the control of the medical school.

One type of postgraduate "specialty" training is offered under the auspices not of the Royal College of Physicians and Surgeons of Canada but of the College of Family Physicians of Canada. These are the family practice programs initiated by McMaster University and University of Western Ontario in their teaching hospitals, in cooperation with the College of Family Physicians. The programs entail rotation among various specialty services, but the nucleus of each is a Family Practice Clinic, staffed by general practitioners with university teaching appointments, in the Henderson General Hospital, Hamilton, and St. Joseph's Hospital, London, respectively.⁷⁶ The Western program involves three years after the completion of medical school; McMaster permits its students to enter or leave in blocks of one year. The admission requirement for these programs is the attainment of the M.D. degree; a year spent in junior internship is not required. A licence to practise, however, is awarded by the College of Physicians and Surgeons of Ontario after the completion of one year of the family practice program, since the first year of the program fulfils the College's requirements for a junior internship.

The College of Family Physicians of Canada now awards Certificates of Advanced Training in Family Practice to candidates who have completed three years of postgraduate training in family practice, one of which may be an approved junior internship. However, the College of Family Physicians of Canada indicated to this Committee that in the event that the rotating internship were abolished or in effect moved into the fourth undergraduate year, it might be able to reduce its postgraduate training requirement to two years.⁷⁷ It is to be hoped that the progressive easing of the internship requirement by the College of Physicians and Surgeons of Ontario noted above will enable this change to be made. The first physicians to complete the above programs were certified in 1969.

Continuing Education

The following words have lost none of their relevance since they appeared in the *Journal of the American Medical Association* on January 27, 1894.

It is the duty of every true physician to hold up the standard of his profession. And to do this successfully he should be both a thorough gentleman and a thorough physician. He should keep abreast of the times, by spending

⁷⁶As noted above, Toronto Western, Toronto General and Kingston General hospitals have also established clinical teaching units in family practice. Although graduate programs are planned, these units have so far been engaged only in undergraduate clinical clerkships.

⁷⁷College of Family Physicians of Canada, Transcript of the Hearings of the Committee on the Healing Arts, October 16, 1967, p. 34. The insistence of the College of Physicians and Surgeons of Ontario upon the inclusion in a postgraduate program of at least one month on each of the four blocks noted above, has necessitated the prolongation of the family practice programs.

at least three months out of every three years at the medical centres, where hospital advantages are offered to the general practitioner as well as to the specialist. This is a duty every true physician owes himself.⁷⁸

Indeed, as estimates of the "half-life" of medical knowledge shrink to a decade or less, continuing education becomes an increasingly important condition of modern medical practice. The Ad Hoc Committee of the American Medical Association's Committee on Medical Education recently argued strongly that *no* formal program of medical education, however meritorious, can guarantee professional competence for long, and that hence:

- 1) The exact length of the formal training program is relatively unimportant.
- 2) Educational institutions initially responsible for training physicians should "assume responsibility for developing and maintaining meaningful continuing educational programs through which their graduates can refresh their basic knowledge and skills and learn of new advances".
- 3) Regular participation in continuing education programs should become a condition of periodic recertification.⁷⁹

The medical faculties of the Universities of Toronto, Western Ontario and Queen's offer non-diploma, non-degree courses for practising physicians. The Division of Post-graduate Education of the Toronto medical faculty offers both brief refresher courses of two to five days' duration for general practitioners, and more extended advanced graduate courses, held over a six-week period in August and September. It also offers decentralized clinics in which a team of teachers travel from Toronto to other localities in Ontario and collaborate with local medical societies to present a one-day program of clinical instruction. The University of Western Ontario medical faculty, through the Committee on Graduate and Continuing Education, offers lectures, seminars, refresher days and short courses, and sponsors videotaped medical educational television programs over the local station during winter and spring months. Queen's faculty's Department of Continuing Education offers refresher courses and symposia for practitioners and lectures, clinics, and conferences both for postgraduate students in its teaching hospitals and for the staff of regional community hospitals.

The sources of continuing education programs available to physicians are not confined to the medical schools. Voluntary associations make available a variety of programs. The CMA and the OMA and their sections hold annual scientific meetings at the time of their annual conventions. The local branch societies in many cases consider scientific and educational activity their primary *raison d'être*.

⁷⁸Quoted in *Journal of the American Medical Association*, Vol. 207, No. 4, January 27, 1969, p. 651.

⁷⁹*Meeting the Challenge of Family Practice*, Report of the Ad Hoc Committee on Training for Family Practice of the Council of Medical Education of the American Medical Association, Chicago, 1966, p. 29.

Presentation and discussion of scientific papers, sometimes by visiting members of university faculties, constitute the large part of the program of their monthly meetings. The Academies of Medicine in Toronto and Hamilton are the outstanding examples of such activity. The College of Family Physicians of Canada is committed to the principle of continuing education, requiring as a condition of membership 100 hours of study credits in two years, to be attained through attendance at scientific assemblies, university courses, or other formal training, and through publication, research or correspondence courses. While this study load is judged not to be excessively onerous,⁸⁰ the executive director of the College estimates the annual attrition rate, largely attributable to failure to meet these requirements, to be 30 per cent.⁸¹ In addition, the specialist societies are important sources of continuing education.

There are some additional programs. Pharmaceutical companies are further sponsors of educational programs. The OMA and the Ontario Hospital Services Commission have established recently a combined program to establish basic libraries in all hospitals in Ontario, and the Academy of Medicine of Toronto will send to a physician outside Toronto, books and medical journals for a yearly fee of ten dollars; the OMA contributes money to this program.

According to members of the profession, funds for continuing education are in short supply. University programs, offered as they are by the medical faculties, not by the graduate schools, must rely upon an allocation of funds directed largely towards undergraduate needs. These funds are supplemented by grants (totalling \$15,000 per year in 1966 and 1967) from the OMA. The OMA also provides travelling expenses and honoraria for out-of-town speakers at branch society meetings.

One of the most important sources of continuing education, as Grove has emphasized,⁸² is informal: "the daily association of the practising physician with the life and work of a large hospital." We wish to emphasize the importance of the hospital in this context, although we shall devote considerably more attention to the matter of hospital privileges below.

Dr. John C. Beck, speaking before the Royal College of Physicians and Surgeons of Canada in January 1969, suggested the development of Physician-in-Residence Programs, whereby a practising physician in a community would relinquish his practice for a period of approximately one month per year, to be spent in a university hospital. Participating physicians would be combined in groups of twelve, so that each man would spend a month away from his practice each year, covered by his other colleagues.⁸³

⁸⁰J. W. Grove, *op. cit.*, p. 238.

⁸¹College of Family Physicians of Canada, Transcript of the Hearings of the Committee on the Healing Arts, October 16, 1967, p. 29.

⁸²J. W. Grove, *op. cit.*, pp. 239-241.

⁸³John C. Beck, "Graduate Medical Education: Crises and Challenge", address before the Royal College of Physicians and Surgeons of Canada, Vancouver, January 1969, mimeo.

One of the most striking documents to come to the attention of this Committee has been the study of general practitioners in Ontario and Nova Scotia carried out by Dr. Kenneth Clute for the then College of General Practice. Although based on small samples in both provinces, the survey constituted the first major Canadian attempt to assess the quality of medical practice and of the determinants and concomitants of this quality. The results of this study are disquieting. Over one-quarter of the Ontario sample were given a rating of forty points or less on Dr. Clute's 100-point scale of quality of practice,⁸⁴ a rating which was considered quite unsatisfactory. Admittedly Dr. Clute's sample was small, but his careful and thorough assessment of that sample produced arresting conclusions. He casts grave doubt on the general quality of medicine practised by numerous physicians. His findings suggest that the length of training taken by physicians does not necessarily have any positive correlation with the quality of medicine practised, particularly by busy doctors working in relative isolation from their professional colleagues. No student of the health sciences can fail to be impressed by the general conclusions and implications of this study. This work emphasizes the need to devote increased attention and resources to continuing education if standards of medical practice are to be maintained and indeed raised.

The present programs in continuing education catalogued above are valuable but they must be greatly expanded. This expansion will, no doubt, necessitate some reallocation of funds within the medical schools in order that the size of the budget for continuing education relative to that for undergraduate education be substantially increased. It will require considerable financial support from the provincial government. The development of these programs, moreover, must allow for a considerable degree of flexibility.⁸⁵ In Chapters 25 and 26 we elaborate the need for assuring continuing competence of at least the senior professions engaged in health care.

Recommendations:

- 11 That a program for ensuring continuing competence be implemented for physicians and that periodically, perhaps every five years, every physician in Ontario be required to present to the College of Physicians and Surgeons of Ontario a certificate from a medical school in Ontario stating that he has maintained a satisfactory level of competence in the areas of medicine in which he ordinarily practises.
- 12 That the Ontario faculties of medicine develop the standards and programs which would be required for such certification; these could include formal course work, a contribution to the profession through research or teaching, or other appropriate methods.

⁸⁴K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963, p. 313. The scale was based on the following items: history taking, physical examination, laboratory work, therapy, obstetrics, preventive medicine and records.

⁸⁵See Chapters 25 and 26 for a much more extended discussion of the case for continuing education. See also J. W. Grove, *op. cit.*, pp. 238ff.

Enrolment

The total enrolment in full-time programs of medical education in Ontario in the academic years 1961-1962 and 1966-1967, and the projected enrolment for 1971-1972 and 1975-1976 is given in Table 8.5.

TABLE 8.5
Enrolment in Programs of Medical Education in Ontario

	1961-1962	1966-1967	1971-1972	1975-1976
Undergraduate	1260	1423	1939	2245
Postgraduate specialty training	643	765	953	1135
Graduate: Master's	53	144	328	515
Doctorate	67	157	345	526
Other	5	24	80	128

SOURCE: *The Health Sciences in Ontario Universities*, Committee of Presidents of Universities of Ontario, June 1966, p. 6. These figures do not include enrolment at a proposed sixth medical school.

Staffing

The issues involved in the problem of staffing the medical schools have been summarized in Grove's study,⁸⁶ and it is not necessary to repeat them here. But the problem is critical. The question Grove has posed is to what extent the required build-up in teaching/research manpower *can* come from new sources of domestic production and from the immigration of university teachers, as against a reallocation of "medical time" from one sector (that of patient care) to another (education and research). If resources have to be shifted from the patient care sector, this will make even more urgent the devolution of greater responsibilities to the related health professions and a more rational organization of medical practice.

In the absence of firm evidence to guide us here towards a constructive decision, we can only state our conviction that this problem is a serious and complex one, but we are unable to offer any specific recommendation. We are hopeful that the results of studies such as those currently being conducted by the Health Sciences Functional Planning Unit at the University of Toronto and by the Association of Canadian Medical Colleges, will provide a firmer basis than now available for decision.

Regulation

Licensing

The sole licensing body for physicians in Ontario is the College of Physicians and Surgeons of Ontario. Its senior governing body, the Council, is composed of the Minister of Health, one member appointed by each of the faculties of medicine

⁸⁶J. W. Grove, *op. cit.*, pp. 206-211.

TABLE 8.6
Physicians Registered in Ontario

Category	1950			1960			1965			1966			1968		
	Additions	Erasures	Total at year end	Additions	Erasures	Total at year end	Additions	Erasures	Total at year end	Total at year end	Total at year end	Total at year end	Total at year end	Total at year end	Total at year end
The Register (full licence)	350	127	5,685 ¹	400	264	9,000 ¹	385	348	9,643 ¹	10,012 ¹	10,012 ¹	10,012 ¹	10,631	10,631	10,631
Special Register ²	6	3	3	12	7	5	229	78	151	350 ³	350 ³	350 ³	674	674	674

¹Includes those residing outside Ontario.

²Renewed annually.

³This is the total number of additions in 1966, not the final number of registrants. Complete figures for the Educational Register for these years are not available. Between July 1, 1965 and June 30, 1966 (the first year in which the registration of internes was compulsory) 872 additions were made to this Register, with 189 erasures. As of December 31, 1968, there were 1,525 internes and residents in approved hospitals, 469 of which were registered on the Special Register or on the Register.

SOURCE: Information submitted to the Committee on the Healing Arts by the College of Physicians and Surgeons of Ontario, 1969.

in Ontario, and twelve members elected on a territorial basis. All members (except the Minister of Health) are licensed medical practitioners resident in Ontario and serve a four-year term. There are three categories of registration (i.e., licensing) with the College: the Register (full licensing), the Educational Register, and the Special Register. The numbers of registrants in specified years are shown in Table 8.6.

The qualifications for admission to the Register (i.e., full practice rights) in Ontario are as follows:

- 1) A degree or other medical qualification granted by a university, medical school, or examining body whose standards of undergraduate education and examination are acceptable to the College of Physicians and Surgeons, and the completion of at least one year of internship in an approved hospital.
- 2) Canadian citizenship or landed immigrant status.
- 3) A certificate from the Medical Council of Canada.
- 4) Good standing with the licensing body in whose jurisdiction he last held a licence (where appropriate).
- 5) Testimony of good character and fitness to hold a licence; in particular, disclosure of any past history of mental illness, alcoholism or drug addiction, criminal record, or professional discipline for misconduct.

The third requirement, a certificate from the Medical Council of Canada, involves a rather complex process of interplay between the Ontario College and the MCC. The possession of either an "Enabling Certificate" or a licence from a provincial licensing body is a prerequisite for sitting the MCC examinations. In the Ontario case, then, those seeking licences from the College of Physicians and Surgeons must first obtain an Enabling Certificate from the College, must then pass the MCC examinations, and finally must complete a year of internship to the satisfaction of the College before earning the designation Licentiate of the Medical Council of Canada (L.M.C.C.). Possession of a certificate from the MCC, then, implies a prior two-stage approval by the College of Physicians and Surgeons of Ontario.

The Educational Register was established in 1952 to allow for the registration of internes in teaching and Group A hospitals. In 1956 it became optional for hospitals in several other categories to register their internes, and in 1965 registration of internes in all public hospitals became mandatory.⁸⁷

In 1960, the College established a "Temporary Register"; in 1966 its name was changed to "Special Register". It comprises a number of categories of practitioners not considered eligible for full registration, who may practise only subject to certain "restrictions, limitations, and conditions". It includes Canadian or foreign

⁸⁷S.O. 1965, c. 107, s. 2. *An Act to Amend the Public Hospitals Act*, R.S.O. 1960, c. 322.

graduates of approved medical schools who have not yet obtained the L.M.C.C., allowing them to practise in hospitals, temporary locum tenens or assistantships, to teach in universities, or to engage in private practice in an area where the services of a fully qualified practitioner are unavailable; the Special Register also includes probationary and miscellaneous cases.

The inclusion on the Special Register of practitioners of indisputably high competence, such as those holding academic appointments, together with those whose competence has been questioned, such as probationary cases, presents a curious anomaly, and may cause needless confusion and embarrassment. The distribution of registration among these categories is shown in Table 8.7.

Compliance with the requirements for full registration constitutes part of a natural progression in the career of a physician trained in Canada, who receives his Enabling Certificate during his last year of medical school, writes the MCC examinations as his final examinations (in most cases), internes for one year in an approved hospital, and duly receives his L.M.C.C. and provincial licence. It is in the case of physicians from other countries that the qualifications of "approved medical schools" and "approved hospitals" begin to complicate the process.⁸⁸ The College approves, with very few exceptions, all medical schools in the United Kingdom, Australia, New Zealand, South Africa, the U.S.A., and the Republic of Ireland. Unlike the regulatory colleges in several other provinces, however, it does not have reciprocity with any of these countries. Graduates of schools in these countries must obtain the L.M.C.C. As we have seen, this entails the obtaining of an Enabling Certificate from the Ontario College. If the graduate has not had a year of internship he must take one; if he has had a suitable internship, he may be licensed on passing the MCC examinations. Until these requirements are met, the "approved school" graduate is placed on the Educational or Special Register and can practise only under the conditions described above.

The licensing regulations for graduates of schools other than those listed above have been progressively eased since we first began our studies. As these regulations now stand, two years of hospital training, at least one of which must be in Ontario, are required of the graduate of any medical school approved by the World Health Organization (WHO) but not included in the above group. In addition, before commencing this internship, the candidate must have passed a screening examination such as that set by the American Educational Council of Foreign Medical Graduates (ECFMG);⁸⁹ and before being granted a licence, he must have obtained the L.M.C.C. As we have seen, this final step involves obtaining an Enabling Certificate

⁸⁸See J. W. Grove, *op. cit.*, pp. 115ff. for a description and discussion of the process and problems of licensure of the immigrant physician.

⁸⁹This Council includes representatives of the American Medical Association, the American Hospital Association, and the American Association of Medical Colleges. Examinations are conducted semi-annually in various centres throughout the world, except in Soviet bloc nations. The requirement that the candidate have passed this examination is waived if he has passed the examinations of the MCC or the Royal College of Physicians and Surgeons of Canada, or a screening examination conducted by a provincial medical licensing authority.

TABLE 8.7
Registrations on the Special Register by Reason for Special Registration, College of Physicians and Surgeons of Ontario, 1950 and 1960-1968 (December 31)

	Graduates of Canadian medical schools	Academic appointments	Temporary employment	Armed forces or public service	Probationary	Special cases	TOTAL
1950				3			
1960				11			11
1961			7	6	1	1	15
1962		4	23	36	3	5	71
1963		4	48	26	3	11	92
1964	8	5	69	45	4	13	144
1965	4	13	121	59	6	25	228
1966	11	15	229	56	6	38	350
1967	21	26	295	67	8	73	490
1968	27	44	406	94	7	96	674

SOURCE: College of Physicians and Surgeons of Ontario, *Report*, January 1968 and 1969. The 1950 figure is from the College of Physicians and Surgeons, reply to Questionnaire "A", Committee on the Healing Arts.

to sit the MCC examination. The College grants this Certificate upon the completion of its two-year internship requirement. However, an L.M.C.C. obtained on an enabling certificate from another provincial licensing agency will be accepted by the Ontario College, provided the certificate was granted on the basis of the requirements currently under consideration by the Federation of Provincial Medical Licensing Authorities in Canada and endorsed by the Ontario College.

There are two alternatives open to the foreign medical graduate who wishes to avoid obtaining the L.M.C.C.

First, if he wishes to specialize in either paediatrics or internal medicine, he may take at least two years of training in one of these specialties in a university-affiliated hospital in Canada, receive an unqualified recommendation from the appropriate heads of Department, and obtain certification, through examination, by the Royal College of Physicians and Surgeons of Canada. This provision makes the Royal College in effect a licensing body. Its approved list of schools is not as restricted as that of the Ontario College. Hence the graduate of a school which is not approved by the Ontario College may obviate the necessity to return to undergraduate school by taking at least two years of specialty training. His specialist qualification thus leads to an effective full licence to practise, despite the fact that he may lack the basic qualifications for a licence in the eyes of the Ontario College.

Second, he may be placed on the Special Register if he takes at least two years' specialty training in a university-affiliated hospital in Canada and obtains a Royal College specialty qualification in pathology, radiology or physical medicine. His practice is thereby limited functionally to his specialty and geographically to a hospital.

Before 1969, the College's regulations concerning foreign medical graduates were even more restrictive. Until January of that year, a distinction was made between WHO-approved schools to which the College extended "qualified approval", and those which it did not approve. Graduates of schools in the latter group were required to insert themselves into the Canadian educational process at the beginning of the third undergraduate professional year; that is, to complete the last two years of the professional course in a Canadian medical school, obtain the M.D., interne for one year, and obtain the L.M.C.C. The alternative of Special Registration in pathology, radiology, or physical medicine was also open to this group.

The 1969 change of policy in effect abolished the distinction between schools given "qualified approval" and those not approved by the College; graduates of all schools formerly in this non-approved group are now treated according to the regulations governing graduates of schools with qualified approval. In August 1969 the College's policy concerning Enabling Certificates was eased. Until that time, a physician who had obtained the L.M.C.C. on an Enabling Certificate granted by another provincial licensing authority (some of whose requirements were less

stringent than those of the Ontario College) would be licensed in Ontario only if he had complied with the Ontario College's requirements for issue of an Enabling Certificate. Among these requirements was the provision that the candidate pass an examination in basic sciences conducted by a provincial licensing authority, by a Canadian university, by the Royal College, or by the MCC. As we have seen, the College of Physicians and Surgeons of Ontario has abolished the basic science qualifications and accepts L.M.C.C.'s obtained on Enabling Certificates granted in accordance with the requirements expected to be adopted by the Federation of Provincial Medical Licensing Authorities.

Despite these changes, we believe that these regulations work considerable hardship upon many highly competent practitioners. The ECFMG examinations are held only twice a year, the MCC examination annually, and considerable time may be wasted in waiting for the sittings. More important, the supervised positions in hospitals, primarily internships and residencies, which the foreign medical graduate must occupy during his probationary period, may be difficult to obtain and are of decidedly inferior status and remuneration. We have heard of complaints by Canadian internes and residents that they are exploited by hospitals which employ them at a modest stipend and demand their service in patient care activities to the detriment of their educational experience.⁹⁰ Such frustrations must be even more onerous to a highly qualified immigrant physician with considerable professional seniority. The number of foreign medical graduates in these positions is substantial (see Table 8.8). Between 1967 and 1968 the number of Canadian graduates interning in Ontario hospitals increased by 2 per cent, while the number of foreign medical graduate internes rose 21 per cent. We have no doubt that in some cases strict supervision and retraining is warranted, but in many others, the College's regulations may constitute an excess of caution which may deter qualified immigrants from entering Ontario.

TABLE 8.8
Survey of Internes and Residents

Year	Canadian universities	U.K., Australia, N.Z., S.A., and U.S.A.	Foreign schools	Total internes and residents
1961	660	57	294	1,053
1962	711	59	248	1,048
1963	734	63	276	1,099
1964	831	105	292	1,237
1965	878	100	309	1,306
1966	783	131	373	1,304
1967	854	177	363	1,394
1968	873	209	443	1,525

SOURCE: College of Physicians and Surgeons of Ontario, *Report*, January 1969, Table V, p. 21.

⁹⁰See, for example, pp. 74-75 above.

Not surprisingly, then, the licensing policies of the College of Physicians and Surgeons of Ontario have come under considerable criticism in recent years. The nub of the controversy is the requirement that the applicant must possess a degree or other medical qualification from a university, medical college, or examining body "whose standards of education and examination are of a quality acceptable to the College of Physicians and Surgeons". The rules implementing this provision have become more and more complex; the resulting confusion has been compounded by the wide variations in licensing practice that exist from province to province, as documented in Grove's supporting study.⁹¹ In 1968, the Ontario College took the lead in the formation of the Federation of Provincial Licensing Authorities, an advisory body comprising representatives of each of the provincial medical regulatory bodies, which is intended to work towards a greater degree of rationalization and standardization of licensing requirements throughout Canada. Its first task, the development of uniform requirements for the issuance of Enabling Certificates, is approaching completion, and has already affected the licensing policy of the Ontario College.

Recommendation:

- 13 That every possible encouragement and assistance be given by the Government of Ontario to the Federation of Licensing Bodies of Canada to develop national standards for licensing of physicians and to facilitate mobility of medical personnel between provinces.

As noted, the provision about approved schools does not affect Canadian graduates, since all Canadian medical schools are approved, and it has had in general only a mildly irritating effect on graduates from the United States and the countries of the old Commonwealth, including Britain, since almost all their medical schools and examining bodies are acceptable also. Its major impact is on immigrant physicians from continental Europe and Asia. From the standpoint of public policy, three issues are involved: the human rights question, the protection of the public against inferior standards, and the need to increase the supply of physicians. As to the third issue, the available statistics indicate that an increase in the number of foreign physicians licensed would not solve the shortage in the remoter areas of the province as is sometimes claimed. Figures released by the College of Physicians and Surgeons revealed that the urban-rural distribution of foreign medical graduates is approximately the same as that of the medical population as a whole.⁹²

On the matter of the licensing regulations, however, we are satisfied that they are devised to protect the public and not to discriminate on the basis of race or colour. Grove concludes from his survey of the licensing policies and practices of the College with regard to foreign medical graduates that:

⁹¹J. W. Grove, *op. cit.*, Appendix II, pp. 140-145.

⁹²College of Physicians and Surgeons of Ontario, Brief to the Committee on the Healing Arts, Part I, 1967, Appendix p. 22, reported in J. W. Grove, *op. cit.*, p. 134.

On one issue there is no doubt, and that is the charge of racial discrimination. There may be racial discrimination in Ontario medicine, but it is not apparent in the licensing regulations themselves, which (as we have seen) discriminate against medical schools on the basis of their quality, not against doctors on account of their race or nationality. A Canadian national who graduated from one of these schools would be on exactly the same footing as a national of the country concerned, just as the United States graduate of a Mexican medical school will find himself disadvantaged in competition for licensing with a graduate of an American school.⁹³

The College has been accused of being "chauvinistic". We do not think it is chauvinistic: merely excessively cautious and conservative, and perhaps, at times, a trifle high-handed. If the defence put up by its spokesmen has been equivocal, as on occasion it has, it must be remembered that it has been under heavy pressure from interests outside the profession. There is little doubt, however, that if the College is to satisfy public opinion it must adopt a more rational classification of medical schools. The present practice of lumping them into classes by country of origin is not defensible. In 1967, the then federal Minister of Manpower and Immigration, Jean Marchand, urged the Canadian medical profession, through its assembled representatives at the CMA's centenary conference to

... cooperate in establishing some Canada-wide system for securing objective assessment of standards of foreign medical schools and relating them to the quality of our own medical training. This could be done in a way which would remove any cause for suspicion of discrimination.⁹⁴

In addition, he made the following offer:

If your Association or the Medical Council or some other appropriate medical body were prepared to institute a program of objective assessment of foreign medical schools, then my Department would cooperate and I think the government would be sympathetic to providing financial support of the investigation.⁹⁵

Recommendation:

- 14 That the College of Physicians and Surgeons of Ontario should establish, in conjunction with other licensing bodies and the Federal Department of Manpower and Immigration, a Canada-wide system to provide objective evaluation of foreign medical schools, but if it is not possible for such a joint program to be developed, that the College of Physicians and Surgeons of Ontario do so on its own.

A second issue concerning the licensing policies of the Ontario College is the requirement that the candidate must be a licentiate of the MCC. This is not so in some provinces, and although it works little hardship for the Canadian graduate, who now almost universally takes it with his university finals, it does have consequences for the British or other old Commonwealth and United States physician.

⁹³J. W. Grove, *op. cit.*, p. 133.

⁹⁴Luncheon Address by the Honourable Jean Marchand, *Manuscripts of the Centenary Conference of the Canadian Medical Association*, Montreal, Quebec, June 19-23, 1967, p. 126.

⁹⁵*Ibid.*

If the recommendation of the British Royal Commission on Medical Education is implemented, all British physicians will, in future, have a degree from a recognized medical school.⁹⁶ In our view, the MCC requirement could well be dropped for graduates of approved schools, such as British-trained physicians, coming to Ontario. The MCC examinations were introduced at a time when standards varied widely from province to province; this is no longer the case, but we believe that the MCC continues to provide a useful national standard for graduates of Canadian medical schools who are qualifying for the first time. We do not believe that these examinations are necessary for the foreign well-trained practising physician when other effective measures exist.

Recommendation:

- 15 That the Medical Council of Canada examinations be abolished for graduates of approved schools who are already registered to practise in their own jurisdictions and whose medical education can be considered equivalent to Ontario medical education up to the obtaining of the licence from the College of Physicians and Surgeons, but that the Medical Council of Canada examinations should be retained for graduates of Canadian medical schools and for those who have not had a medical education equivalent to that received in Ontario.

Recognition of Specialists

The Special Register discussed in an earlier section is not to be confused with the recognition of specialists in the province. The College of Physicians and Surgeons of Ontario is by law the "specialty recognizing" body in Ontario; no physician may use a specialist designation, or receive reimbursement from health insurance agencies on the basis of the specialist fee schedule, unless he appears on the list of specialists maintained by the Ontario College, although any duly licensed medical practitioner in Ontario may restrict his practice (outside a hospital) to a particular specialty. The College recognizes as specialists among its members only those who possess a certificate or fellowship from the Royal College of Physicians and Surgeons of Canada.

The increasing specialization of medical training and practice has given rise to proposals, from both within and without the profession, for the extension of specialist registration to constitute a form of "limited licensing". Grove raises the issue:

. . . of the reality under modern conditions of the concept of the "full" licence to practise any form of medicine: to be specific, is the "full" license any longer realistic? or should we move to a "limited licensing" situation

⁹⁶The Conjoint Diploma of the Royal College of Physicians of London and the Royal College of Surgeons of England, held by the Ontario College not to involve standards lower than those set for a degree from a British university, would, on the recommendation of the Commission, be taken only after graduation from medical degree course in Britain. *Royal Commission on Medical Education, 1965-68*, Cmnd. No. 3569, Her Majesty's Stationery Office, London, 1968, p. 117. See the discussion of the "Conjoints" in J. W. Grove, *op. cit.*, pp. 118-119.

in which *all* doctors would be licensed to perform *only specified types of medicine*, perhaps including family practice —substantially redefined and no longer coincident with “general” practice — as one of these types?⁹⁷

It is evident, however, that the institutionalization of medical care has brought about a system of de facto limited licensing, limiting the performance of many sophisticated procedures to practitioners whose hospital privileges allow them access to the complex diagnostic and therapeutic equipment of the hospital, and circumscribing, through hospital regulations, the in-hospital practice of these practitioners. Forms of combined practice outside hospitals also involve some element of review, albeit an informal one. But we believe that a large element of reliance, for practice by individual physicians within his competence, must be with the physician himself. We believe, however, that the College should keep an eye on whether such self-limitation is exercised.

Recommendation:

- 16 That graduates from Ontario medical schools continue to receive a full and undifferentiated licence to practise medicine at the end of the internship year, and that practitioners from outside Ontario who have been trained in programs similar to those which presently exist in Ontario, continue to be eligible for licensing for full practice as at present; but if it should appear to the College of Physicians and Surgeons of Ontario that physicians are practising beyond their competence, serious consideration should be given to limited licensing.

We are aware that in making this recommendation we are approving a system which has produced, and will continue to produce, practitioners of varying levels of competence in different aspects of medicine. We are also aware that the medical profession has striven constantly to avoid double standards or any acceptance of inferior qualitative levels of practice. The passage of time, together with increasingly sophisticated medical technology, make necessary a frank recognition that not all physicians can possibly adhere to the more advanced levels of skill in particular fields, demonstrated by more highly trained specialists. No longer can the myth be accepted that “a doctor is a doctor”. The realization must be faced that varying levels of competence and specialization exist in the medical profession as in all professions. It is quite conceivable that at some future date specialist qualifications will become a condition of licensure, and a formal system of limited licensing will obtain. But at present such a system is impractical in the Ontario context.

Since the foregoing recommendation concerning an undifferentiated licence hinges in large measure upon our recognition of the fact that hospital medical staffs in effect have assumed informal quasi-licensing functions, it is appropriate that we devote some attention at this point to the functioning of these bodies. For a fuller treatment, the reader is referred to Chapters 7 and 27. As we explain there, hospital privileges are awarded, not by the College of Physicians and Surgeons, but

⁹⁷J. W. Grove, *op. cit.*, p. 133.

by the hospital boards themselves, on the advice of their Medical Advisory Committee. Here additional requirements bring other non-licensing bodies informally but effectively into the "licensing" process. Many hospital staffs, for instance, demand Royal College certification or Fellowship of the specialists on their staff; some also demand that their general practitioner staff members be members of the College of Family Physicians.

The statutory basis for the power of the hospital medical staff is Regulation 523, issued in 1960 under the Public Hospitals Act of Ontario, which made compulsory the functioning of the medical staff of each public hospital in Ontario as the body through which (technically, on whose advice) the use of hospital facilities by medical and dental personnel is regulated. Ultimate control, of course, rests with the lay Board of Trustees, but *de facto* control rests with the medical staff. Regulation 523 requires the medical staff to hold monthly meetings and to set up committees to supervise the activities of the medical and dental personnel.

The agency responsible for the allocation of hospital privileges is the Medical Advisory Committee of the medical staff. In Group A hospitals it is appointed by agreement between the university and the hospital, and usually comprises the chiefs of the various services and the elected officials of the medical staff; in all other hospitals it is elected by the staff organization for appointment by the Board.

Grove summarizes the power structure with regard to hospital privileges:

In the large departmentalized hospitals, the head of Department is in a very powerful position, with the President of the Medical Staff and other medical staff officers acting, so to speak, as shop stewards "watching the management on behalf of the rank and file". There is no right of appeal beyond the Board of Trustees for any aggrieved G.P. or specialist whose application for hospital privileges is refused, whatever the size and nature of the hospital. In the small local or community hospital the applicant (generally a family doctor) is notionally at the mercy of his brother physicians already on the staff; on the other side of the coin, however, the spirit of freemasonry of the profession urges them to accept him if he is at all competent and has something to offer. In the larger hospital, the young specialist applicant may be caught up in the medical bureaucracy or become a victim of the Departmental struggle for beds; the general practitioner applicant may be admitted for outpatient and emergency department work (including some minor surgery) without difficulty, and then find that he cannot get his patients admitted because beds are so rarely available.⁹⁸

A considerable amount of commentary and some survey evidence, discussed in Chapter 27, suggest that discrimination against and resultant dissatisfaction among general practitioners is more acute in large hospitals, and particularly in teaching hospitals.

We have emphasized the importance of the hospital to the modern physician, not only in the conduct of his practice, but in the maintenance and improvement

⁹⁸*Ibid.*, p. 135-136.

of his professional competence and skills. In his study, Clute devoted considerable attention to the problems of general practitioners. He concluded that:

. . . it appears that some practitioners' difficulties in keeping up with recent advances or in making good the deficiencies in their original training were the result of lack of stimulation which in turn was the result of professional isolation. This we regard as one of the strongest arguments against any system of medical practice that would exclude a general practitioner from the hospital and hence tend to isolate him.⁹⁹

Clute bolstered his argument with quotations from various distinguished members of the profession, including the categorical statement by Dr. Morley A. R. Young, former president of the CMA, that:

Whenever hospital privileges are denied, someone has caused a step to be taken which lowers the standard of practice.¹⁰⁰

We are convinced that hospital privileges have too great an importance to the practitioner of modern medicine to be left solely to the discretion of the Medical Advisory Committee of hospital medical staffs. In particular, consideration of the long-range detrimental effect of exclusion from educational experience within the hospital upon the competence of a physician makes apparent the necessity that the problem of restriction or denial of privileges to family physicians be resolved. In view of the importance of this issue and of the wide differences in the rules which obtain from one hospital to another, we believe that in general, physicians who desire hospital privileges should have an increased opportunity of obtaining them. In Chapter 30, we discuss this matter again in relation to the problems of the general physician, and the reader is referred to Recommendation 351 in that chapter.

We also propose in Chapter 25 the creation of a Health Commissioner whose duties will include, among other matters, hearing of complaints and making recommendations concerning the complaints laid by physicians who are unable to obtain hospital privileges.

We shall have occasion to return to this matter in considering the disciplinary activities of hospital medical staffs in Chapter 27.

On particular issues of medical regulation, only one other major point remains to be dealt with here: the issue of corporate practice. This Committee has heard no evidence to suggest that the corporate practice of medicine would be injurious to the public interest. We have discovered no reason to disagree with the findings of the Select Committee on Company Law (1967) that "it seems unrealistic to prohibit medical, legal, accounting and architectural practices, for example, from being carried on in incorporated form when at the present time such practices are in fact carried on, in some cases, in very large partnerships".¹⁰¹ Furthermore, it

⁹⁹K. F. Clute, *op. cit.*, p. 462.

¹⁰⁰Quoted in *ibid.*, p. 119.

¹⁰¹Province of Ontario, Interim Report of the Select Committee on Company Law, 1967.

would be naive not to acknowledge that, de facto, the corporate practice of medicine now exists, insofar as hospitals, being corporate bodies controlled by lay personnel, are indeed "practising medicine".

Recommendation:

- 17 That physicians be permitted to incorporate for the practice of medicine in Ontario, but that ownership of shares in such corporations be restricted to physicians licensed to practise in the province of Ontario.

For our view of the nature and implications of the licensing powers, the reader is referred to Chapter 25. Rather than be unduly repetitive it will suffice to indicate our desire to incorporate by reference, with relation to physicians, the treatment of the subject to be found there.

Recommendation:

- 18 That there be representation from the Department of Health and significant lay representation on the Council of the College of Physicians and Surgeons of Ontario.

We will return to this issue in subsequent chapters, and particularly in Chapter 25.

Voluntary Associations

The plethora of voluntary professional associations in medicine bears witness to the great diversity of skills and interests within the profession itself.¹⁰² The umbrella organization, the Ontario Medical Association, is open to all physicians registered with the College and resident in Ontario; more than three-quarters of the physicians in Ontario belong to it. Functional divisions within the profession are manifested both within the OMA by its various sections and without by the College of Family Physicians and the various specialist societies. Geographical divisions are represented by the local medical societies. Other organizations have evolved around particular types of employment, such as the Canadian Life Insurance Medical Officers Association, or have arisen to provide benefits to members of the profession, such as the Canadian Medical Protective Association.

Although there is some overlap, the various organizations tend each to perform a different function for their members. The OMA was founded in 1881 "to cultivate the science of medicine, to advance the character and honour of the profession, to raise the standard of medical education, to promote public health, to further unify and promote harmony among the members, and to form a connecting link between the local medical societies and the Canadian Medical Association".¹⁰³ These objectives, save the last, are fairly typical of the stated purposes of most of the professional associations under consideration here, but there has evolved a de facto division of function rather unrelated to the original

¹⁰²See J. W. Grove, *op. cit.*, Ch. 3.

¹⁰³Charter of the Ontario Medical Association, Section V.

charter provisions. Although scientific matters are discussed within the sections of the OMA, and its monthly journal provides an exchange of professional information, the organization as a whole is concerned, in substantial measure, with the relations of the profession as a whole with the larger society, and in particular with government.¹⁰⁴

The main thrust of this activity, Grove notes, has been towards the "furtherance and protection of the material interests of its members by all lawful means".¹⁰⁵ While the OMA has undertaken a good deal of the political and public relations activity,¹⁰⁶ it is fair to say with Grove that medical-economic matters are of "overriding importance". Important among these, of course, is the determination of the fee schedule which, while not binding upon the members, assumes increasing importance as the basis for payment under medical insurance schemes. The fee schedule is revised every two years by the OMA's Committee on Tariff, which receives submissions from the various specialty sections and advice from the Committee on Economics and Medical Practice and the Board of Directors. Revisions made must be ratified by the Council of the OMA. We shall return to the matter of the setting of professional fees after a brief consideration of the structure of professional voluntary associations.

As Grove notes, the model for policy formation by the OMA is one of "democratic centralism";¹⁰⁷ policy is to be thoroughly discussed by representatives of the "grass roots" organizations, but once a decision has been made by a majority of their number, it becomes official OMA policy, to be advanced by all subordinate branches. To a large extent, and for the more consequential decisions, this model holds, but it is inevitable that certain decisions devolve to the committees of the association, to its Board of Directors, or to the growing administrative apparatus at OMA headquarters. Grove states that most briefs, exclusive of those relating to the tariff or medical insurance, originate in committee and then go to the Board of Directors for decision, without debate or ratification by Council which meets only two or three times a year. As a whole, however, the OMA at least according to Grove's respondents, is felt to represent the medical consensus in the province, although it may take the lead in its formation.¹⁰⁸

The formal arrangement between the OMA headquarters and its branch societies are of various kinds. The OMA comprises sixty-one territorial divisions, subsumed under eleven district associations. In each territorial division, a local

¹⁰⁴Indeed, the enumerated objectives of the OMA now include "the advancement of medical legislation for the good of the public and the profession", Section V: 8.

¹⁰⁵J. W. Grove, *op. cit.*, p. 26.

¹⁰⁶For example, resolutions adopted at the annual meeting of the OMA Council in 1966 approved pressure for legislation concerning air and water pollution, driving safety, the needs of youth, and coroners. Public relations activities are various. Notable examples, in addition to the publication of numerous pamphlets, are "Mediscope"—a public relations and recruitment display, presented at high schools throughout the province—and the Central Mediation Committee to be discussed below.

¹⁰⁷J. W. Grove, *op. cit.*, p. 35.

¹⁰⁸*Ibid.*

medical society acts as a "branch" of the OMA. Membership in a local society, however, does not automatically confer membership in the OMA, although most local societies encourage their members to join the larger association. Electorally speaking, however, the local societies are sovereign within their respective territories; they elect representatives of the division to the OMA Council, the governing body of the Association, which also includes representatives of the district associations. Other OMA organs in order of decreasing size and increasing administrative importance, are the twenty-four member Board of Directors (eighteen elected by the district association, five elected by Council, and one appointed by the medical schools) and the five-member Executive Committee.

Beyond their electoral similarity for OMA purposes, the local societies vary greatly in vigour and activity. The nature of the society depends largely upon the circumstances of its birth. Those which existed as independent societies before joining the OMA, such as the Academies of Medicine in Toronto and Hamilton, tend to be more vigorous than those formed specifically as branch societies. Least active of all, as a general rule, are societies formed when a hospital staff decided to apply for status as a branch society of the OMA, thus securing independent representation on the OMA Council and access to speakers' grants and other OMA benefits. The local societies do act as public relations arms of the OMA; but as we have seen, most activity in this field occurs at the well-equipped headquarters level. The chief functions of the local societies (where they assume any importance beyond their OMA electoral function, and in some cases they do not) are to serve as scientific forums and to foster social bonds within the profession.

It is common to find an increasing importance in the professional's universe, of the more restricted circle of colleagues comprised by the association within his specialty. Grove provides a partial list¹⁰⁹ of seventeen specialist associations, all national, but many having Ontario equivalents, and some even local chapters. Their importance in the formation of professional opinion generally has been overlooked in the lay reliance upon the OMA as the voice of the profession.

The equivalent of the specialist society for the general practitioner is the College of Family Physicians of Canada (until 1967, the College of General Practice). Formed in 1954, with assistance from the OMA, to advance the cause of the medical generalist, the College possesses a headquarters in Toronto and a chapter in each province. The membership of the Ontario chapter (1,162 in 1967) constitutes roughly half of the national membership and about 28 per cent of all the family physicians in Ontario. The annual drop-out rate on a national basis, however, is about 30 per cent,¹¹⁰ a figure whose size is largely attributable to failure by members to fulfil the requirement of 100 hours of continuing study every two years, which is a condition of membership. The College is the only professional medical association in Ontario with such a study requirement. The

¹⁰⁹*Ibid.*, p. 45.

¹¹⁰College of Family Physicians of Canada, Transcript of the Hearings of the Committee on the Healing Arts, October 16, 1967, p. 29.

College, furthermore, has been active in establishing postgraduate educational programs in family practice, and in April 1968, was recognized by the Royal College of Physicians and Surgeons as the certifying body for the new "specialty" of family practice.¹¹¹

The all-embracing professional association in Canada, of course, is the Canadian Medical Association, of which the OMA is technically a division and all others mentioned above are affiliates.¹¹² Since most health legislation has been formulated at the provincial level, the CMA has done little in the way of detailed recommendations for legislation, leaving this to its provincial divisions, which enjoy substantial autonomy. Through its committees and its annual meeting, however, it provides important foci for the coordination of provincial policy with regard to medical insurance plans, through its Committee on Medical Economics, with its "Fourteen Points" issued in 1960, its representation before the Royal Commission on Health Services, and its annual pronouncements on the occasion of the annual meeting. As Grove notes, however,

. . . the CMA is itself a federal structure which must act cautiously and, in form at least, with the step-by-step consent of the Divisions. Its relationship with the provincial medical associations has emerged slowly and reflects, even now, a tension between concern over the consequences of fragmentation in the medical profession and a desire to adhere scrupulously to a constitutional division of functions. A national policy for organized medicine in Canada, insofar as it is possible at all, can emerge only through the existing interlocking network of provincial and national committees.¹¹³

The CMA also encourages the development of national standards of medical services by performing accrediting functions (for training programs for internes, laboratory technologists and radiological technicians) and by fostering the establishment of such national bodies as the Medical Council of Canada, the Canadian Hospital Association, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada.

Relations with Government

In the final chapter of his study, Grove discussed the state of relations between the organized medical profession (represented, in this context, primarily by the OMA) and the public authorities. His belief is that the medical profession and the government still have to achieve that relationship which will function best in working out a whole range of health care problems. This will, no doubt, require some organizational changes on both sides, but the crux of the problem is the creation of a better atmosphere of cooperation. The OMA, almost alone now among the provincial medical associations, has steadfastly refused to take any step that would even appear to imply a commitment to deal with the government on anything but an "arms-length" basis. There are, however, two sides to every

¹¹¹See the discussion of the implications of this "recognition" in Chapter 30.

¹¹²J. W. Grove, *op. cit.*, p. 36.

¹¹³*Ibid.*, p. 38.

argument, and it is incumbent on the public authorities to conduct their affairs with the medical profession in such a way as to alleviate and not exacerbate an already delicate situation. There is some evidence that the government has not always handled its business with the profession as diplomatically and as straightforwardly as it might have done.

The need for closer and more cooperative relationships between the profession and government is particularly important in the matter of the setting of fee schedules. In a profession in which entry is restricted by licensing to those with particular qualifications and competence, the setting of fees by the profession alone has monopolistic effects. Furthermore, in a situation in which most of the medical expenses for almost the entire population of the province are met through government-sponsored health insurance plans, the professional fee schedule becomes a matter of considerable public importance, and its determination cannot be left to the unilateral dictation of the profession. Appropriate machinery for negotiation of fees must be established. We shall recommend the creation of a Fee Negotiations Advisory Committee and discuss this machinery at greater length in Chapter 24; here we draw attention to two of its major implications. First, the fee schedule should be the maximum fee that ordinarily is charged. Second, in setting the fee schedule negotiators should be mindful not only of the total cost of medical services to society but of the effects of the schedule upon the distribution of physicians among various types of practice. Incentive schemes can be usefully employed to direct medical resources to particular fields of medicine and types of organization in accordance with society's needs.

Recommendations:

- 19 That the fee schedule published by the Ontario Medical Association be a matter of prior negotiation by the Association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.
- 20 That the fee schedule thus negotiated should ordinarily be the upper limit of the fee charged.
- 21 That in negotiating fees with physicians, the government in cooperation with the physicians consider methods of using the fee schedule to direct medical resources according to community needs and priorities.

Quality Control

We have now discussed the bodies chiefly involved in the complex mechanisms of quality control within the profession: the College of Physicians and Surgeons of Ontario, the hospital staffs, and the OMA with its local branches. In surveying this machinery, we shall concern ourselves first with the disciplinary process which, though a negative aspect of quality control, is nonetheless of crucial importance; disciplinary sanctions are, after all, what gives teeth to professional standards of quality.

Since, as hardly need be reiterated here, the power to grant licences implies the power to revoke licences, the College of Physicians and Surgeons is the ultimate disciplinary body for the medical profession in Ontario. It deals with all charges of "misconduct in a professional respect or conduct unbecoming a medical practitioner, or incompetence". It may be noted that only allegations drawn to the College's attention by members of the public, the press, patients, other physicians, insurance agencies, and the like, become the basis of disciplinary cases; the College itself has no formal policing mechanism. It shares with the Royal College of Dental Surgeons of Ontario one full-time investigator. Many of the cases investigated by the College involve non-members of the College allegedly practising medicine in violation of the Ontario Medical Act, but we shall be concerned here only with the procedure for dealing with members of the College.

Complaints received by the College pass through a number of screening mechanisms and, as we shall see, may have passed through one or more filters before reaching the College. The first is the Registrar, who disposes of minor complaints with an explanation to the complainant and/or a warning to the practitioner involved, and refers more serious cases to the Complaints Committee, which in turn disposes of the more minor cases and refers the others to the Discipline Committee. Some of the complaints cannot be completely disposed of by the Discipline Committee but must also be considered by the Council of the College. In either case an appeal lies to a judge of the Supreme Court of Ontario with a further right of appeal to the Court of Appeal.

The criteria for judgment and sentencing are not clearly defined. In some cases, of course, as in the extreme case, when a physician has been convicted of any indictable offence, the decision is straightforward. To aid in the disposition of less serious cases of "professional misconduct", the College publishes a list of principles and regulations, based on the CMA Code of Ethics, concerning such matters as advertising, dispensing and prescribing of drugs, fee splitting and referral.

OMA headquarters and the local medical societies each have Ethics Committees, but these bodies typically function, if at all, as amanuenses for College decisions. Complaints of an ethical nature received by the OMA are referred to the College.

The CMA Code of Ethics, the basic code of professional self-discipline in Ontario, is at present under review. Grove noted a number of anomalies in the existing code¹¹⁴ which we hope will be removed following the full-scale revision which the CMA is now undertaking.

We note that the decision to discipline a physician, and in what way, depends, in part, on the local "supply situation". For example, a physician in an underserved rural area may be allowed more leeway, whereas a man from an area where the

¹¹⁴*Ibid.*, pp. 171-173.

number of physicians is adequate, or more than adequate, might be disciplined. No doubt in any self-governing body or corporation such things have to be lived with. We believe, however, that public doubts about such matters would be allayed if laymen were to be associated with the College in the disciplinary process. We should, perhaps, point out that the British General Medical Council has a lay member on its disciplinary committee. The presence of laymen is desirable, not only to represent the public interest, which is stronger, in this context, than most members of the medical profession have been prepared to admit, but also to help ensure that justice is done to physicians. In saying this, we are not thinking simply of the hearing of particular cases, but also of the *policy* relating to the bringing of disciplinary cases.

This is not to say that we regard the College's disciplinary machinery as defective. On the contrary, it is reasonably well designed to effect its purpose, and we were impressed by the fact that the College tries hard to ensure that its very considerable powers are exercised with discretion and humanity. But if there is nothing to hide, there is no reason to object to public representation.

We were much less happy about the "ethical" activities of the local medical societies, not because we think it is undesirable to try to deal informally and locally with potential disciplinary problems, but because the review of this machinery, such as it is, rests with the OMA and not the College. If, as is reported, the College "favours the handling of minor ethical problems at the local level",¹¹⁵ it should not object to assuming this supervisory responsibility itself. The disciplining of physicians *for certain (though not all) offences* — incompetence and negligence, overcharging, and the like — is not a matter for the profession alone. The Disciplinary Committee of the College, indeed the whole disciplinary process, is part of the structure of administrative law and it should be subject to public safeguards.

We have recommended, for reasons noted previously, the inclusion of lay representatives of the public on the Council of the College of Physicians and Surgeons of Ontario. We believe the extension of such a policy of lay representation to the College's Disciplinary Committee to be in both the public and the professional interest.

Recommendation:

- 22** That there be lay representation on the Discipline Committee of the College of Physicians and Surgeons of Ontario.

An agency even more active than the College of Physicians and Surgeons in the quality control and disciplinary process, because it is more immediate to the practising physician, is the hospital medical staff. We have noted above the importance of the medical staff of the hospital as a *de facto* "licensing" agency; we now turn to its corollary functions of quality control and discipline.

A more extensive discussion of the regulatory activities of hospital medical staffs can be found in Chapters 7 and 27. Only a brief summary is included here.

¹¹⁵J. W. Grove, *op. cit.*, p. 174.

A check is kept upon the physicians' activities within the hospital by other staff committees: the Tissue Committee, which examines the pathologists' reports on all tissue removed; the Admission and Discharge Committee, which supervises determination of the necessity and length of patient stays in hospital; and the Records Committee, which supervises the keeping of patient records. The growing regulatory power of the hospital in the U.S.A. has led Somers and Somers to remark that "the hospital has become the most powerful standard setter or police agent of the medical profession today — one reason it has become so controversial".¹¹⁶ It is crucial to note, however, that in Ontario this power resides *de facto*, not with the hospital, but with its collective medical staff.

We note the use made by some eighty hospitals in Ontario of the computer programs and facilities of the Hospital Medical Records Institute in conducting a thorough medical audit. The hospital provides an excellent locus for the assessment of the physician in his day-to-day clinical activities, and facilitation of this assessment is to be encouraged. We note that the Hall Commission recommended the extension of "professional activities studies",¹¹⁷ such as those of the Hospital Medical Records Institute, which are aimed at improving quality control. We agree with this recommendation. Although there are numerous difficulties, the regular measurement of quality of care and, further, of the effectiveness of investigation and treatment as one aspect of quality, is of overwhelming importance, and substantial resources should be devoted to its development and improvement. Whether this should be done by expanding support for the Hospital Medical Records Institute, or by the creation of a new agency, is not for us to say.

Recommendation:

- 23** That professional activities studies aimed at improving quality control, such as those of the Hospital Medical Records Institute, be extended, that more public resources be made available for their support.

We have considered this matter at greater length in Chapters 7 and 27. We draw attention to it here to emphasize its importance.

Since 1960, the hospital medical staff has also had formal disciplinary powers. Regulation 523, under the Public Hospital Act, issued in that year, which provided for compulsory medical staff organization in the hospital, also required the Medical Advisory Committee to "make recommendations to the board concerning the dismissal, suspension, or restriction of hospital privileges of any member of the medical staff or dental staff who contravenes any provision of the by-laws, the Public Hospitals Act, the Hospital Services Commission Act, or the regulations under these Acts". Hence the disciplinary function of the Medical Advisory Committee involves judgments not so much concerning professional ethics as concern-

¹¹⁶H. Somers and A. Somers, *Doctors, Patients and Health Insurance*, The Brookings Institution, Washington, D.C., 1961, p. 113.

¹¹⁷*Report of the Royal Commission on Health Services*, Vol. I, *op. cit.*, p. 53, Recommendation No. 96.

ing organizational regulations, such as keeping up-to-date medical records, and competence and quality of care.¹¹⁸ Great discretion is allowed the committee in the latter fields, since its collective expertise virtually cannot be challenged by the lay administrators. Given this discretion and the effectiveness of the sanctions available (suspension or revocation of hospital privileges is tantamount to denial of practice in many cases, especially for specialists) the Medical Advisory Committee becomes an extremely powerful disciplinary body. Its sanctions are made even more effective by the statutory requirement¹¹⁹ that all cases in which a physician is disciplined be reported to the College of Physicians and Surgeons, hence reducing the possibility that the physician may nullify the effect of his "sentence" by obtaining an appointment to the staff of another hospital. This provision may have another consequence, however: the disciplinary activity of the medical staff may be curbed by the knowledge of the staff that disciplining a colleague endangers his standing with the licensing authority. The degree to which this requirement deters the staff organization from taking disciplinary action can only be surmised. The College, in practice, has felt that the closer scrutiny afforded the members of the hospital staffs over their colleagues, better equips them to make a determination in a disciplinary case, and has upheld the verdict of the Medical Advisory Committee. It maintains that it would not hesitate to overturn a verdict or a sentence which it felt to be unfair, or to discipline a member of a Medical Advisory Committee whom it felt to have dealt unfairly with a colleague. Since such a member would almost certainly be the chief of the service involved, however, to do so would be tantamount to a "vote of non-confidence" in the chief and would virtually force his resignation.

This devolution of considerable disciplinary power upon hospital staffs allows for arbitrary use of this power. Grove has noted the wide variations in disciplinary policies and practices among hospital staff.¹²⁰

It must be realized that, despite this provision for the registering of disciplinary decision, there exists no right of appeal on the part of the disciplined physician beyond the Medical Advisory Committee.¹²¹ We have stated our conviction, in connection with our discussion of hospital privileges, that this power must be tempered, and that decisions of a Medical Advisory Committee might be subject to a complaint by the aggrieved practitioner to the Health Commissioner the creation of whose office is recommended in Chapter 25. Similarly, disciplinary decisions of a Medical Advisory Committee should also be within the competence of the Health Commissioner to investigate upon complaint of an interested party. In view of our concept of the office of the Health Commissioner as described in Chapter 25, recourse by an affected person to the Health Commissioner is not tantamount to a right of appeal with consequential coercive sanctions to enforce

¹¹⁸J. W. Grove, *op. cit.*, pp. 175-176.

¹¹⁹S.O. 1965, c. 107, s. 5.

¹²⁰J. W. Grove, *op. cit.*, p. 177.

¹²¹Except to the Board of Governors, who almost always defers to the expertise of the medical staff.

the decision of an appellate tribunal. We believe, however, that the Health Commissioner's powers to publish the result of an investigation is a sufficiently salutary guarantee of fairness and of what has become known to students of public administration as natural justice, that yet another appellate tribunal and formal appellate machinery are unnecessary.

One further aspect of the process of quality control is performed by the local voluntary associations through their mediation committees, which deal with complaints by patients against physicians. The most common charge concerns the size of the fee. The OMA maintains a Central Mediation Committee at its Toronto headquarters, but prefers this to function as a "court" of first instance only for the Toronto area, and encourages the handling of mediation disputes at the local level, with the Central Mediation Committee as a "court" of appeal. Although the OMA has required its local societies to form mediation committees, most of these function rarely if ever. The paucity of complaints received may reflect consumer ignorance of the machinery for registering grievances as well as patient satisfaction. A list of complaints disposed of by the OMA Central Mediation Committee during one month included, in addition to those concerning fees, complaints about physicians' refusals to complete forms, make house calls, hold telephone conversations, and the like. The nature of these complaints reflects a modern reality, the fact that medicine is a *public* service. It therefore appears to us quite wrong that the machinery for handling disputes between physician and patient should remain under the control of a voluntary association, the Ontario Medical Association. Nor is it right that the only sanction should be a disciplinary one, exercised by the College. There are, of course, difficulties, familiar to students of public administration, in attempting to give adequate protection to the consumer: in particular, in making the existence of the protective machinery widely known. But these difficulties are by no means insurmountable and certainly not sufficient to discourage an attempt to represent the consumer interest in cases of grievance. Complaints by patients against practitioners could be made to the Health Commissioner, who should be empowered to investigate and, where he deems advisable, publish the results of his investigation into such complaints.

Relations with Other Professions

We have had occasion throughout this chapter, as throughout the rest of our Report, to comment upon the importance of cooperation among the health professions. Health professionals must come increasingly to consider themselves as members of a "team", and the physician's position as the pivotal member of this team makes it all the more important that he be aware of his responsibilities to the others. We shall deal with this concept at greater length in later chapters. Here we note only some particular aspects of the relationships between medical and non-medical professions which require some alteration.

The statutes governing the practice of each of the non-medical health professions contain clauses exempting duly licensed members of the medical profession

from the provisions of these Acts, in effect allowing physicians to practise within the areas reserved to the non-medical health professions subject only to the provisions of the Medical Act. This right of physicians, we feel, entails a certain responsibility to consider the regulations governing practice in non-medical areas. In the specific case of physicians' activities in relation to prescribing and dispensing drugs, we offer the following recommendations which should be read in conjunction with Chapter 11 on pharmacists.

Recommendations:

- 24 That physicians selling drugs to their own patients be required to comply with the laws governing the sale of drugs by non-physicians and keep the same records of prescriptions dispensed, including the number of times it has been filled, and so on, as are required of a pharmacist, but that this would not apply to dosages given as a direct treatment in the home or office by the physician.
- 25 That a physician should, upon the request of a patient, supply to the patient a written prescription of any drugs prescribed for the patient.
- 26 That medical students be taught and physicians be encouraged to prescribe generically when feasible.

We believe, moreover, that the physician's right to practise in non-medical areas and his predominant position among health professionals entails an obligation, where possible, to contribute to the raising of the quality of service provided in these areas. For this reason, we do not regard as justifiable the provisions in ethical codes of some medical societies of clauses precluding physicians from teaching students in non-medical health fields. We shall make specific reference to this point in Chapters 12 and 21 concerning optometry and chiropractic.

Recommendation:

- 27 That medical codes of ethics should not preclude physicians from teaching non-medical students in the healing arts or participating in continuing education programs for personnel already qualified to practise in any of the healing arts.

Conclusions

At the outset of this chapter we drew attention to the susceptibility of the medical profession to the forces of social change. In a period of rapid technological development and social change, the institutional, legal and professional problems of modern medicine are acute and complex. If the medical profession has not always been creatively responsive to these forces, it cannot be denied that the physician's concern with the care of his patients is intense and sincere, and may have eclipsed broader social considerations. Hence in framing our recommendations in this chapter, our intention has been to serve and protect the best interests both of the physician and of the public. In so doing we recognize that a just balance of these

interests requires a perspective broader than that of the profession itself, which has sometimes tended to identify its professional interests with traditional forms and practices rather than with the adoption of an innovative social role.

The existing schemes of education and regulation in the healing arts' disciplines have been based upon a model of the physician as an independent practitioner, broadly trained to make a diagnosis based on "a thorough understanding of the structure and function of the whole human body and the pathological conditions that may occur in any part of the body",¹²² and holding sole responsibility for his patient. In this day of increasing specialization and institutionalization in medicine, it must be asked whether this model is obsolete, whether the educational and regulatory processes have lagged behind the reality of the physician's development into a member of an increasingly complex team of health personnel, including colleagues in the medical profession, members of other professions, and paramedical personnel. With the explosion of medical knowledge, the physician's competence has tended to become restricted in breadth as it increases in depth, even in the realm of family practice. His responsibility for his patient is shared increasingly with colleagues and with the institutions in which more and more of his practice is carried out. The educational and regulatory process, we believe, can be brought into line with the existing realities of modern medical practice without doing violence to the concept of professional self-regulation, but this requires that the profession recognize both the physicians' changing role and the expanding contributions of other components, institutional, professional, and subprofessional, of the health delivery system.

The problems of modern medicine in relation to changing social forces are by no means unique to Ontario or to Canada. These problems are of a general and world-wide nature, and confront the medical profession throughout the western world.

Dr. K. Evang of the Health Services of Norway, Ministry of Social Affairs, has synopsized the social position and prospects of the medical profession in most nations. We quote him here at some length to underline the importance of the views he expresses. Dr. Evang emphasizes:

. . . the iatrogenic traditional factors limiting the improvements of health control. By this I mean the traditional factors found within the medical profession itself, and which at the present stage of development prevent, hamper or distort the optimum development of health services.

To avoid misunderstanding, let it not be forgotten that the medical profession on the whole has been a driving, dynamic force in the development of effective health control measures. My task here, however, is not to enumerate the many positive aspects, but to point to some negative ones.

By tradition medical doctors belong to the conservative forces in society, as do most other social groups with higher education, secured economy,

¹²²One of the six principles enunciated by the College of Physicians and Surgeons of Ontario to be used as criteria in determining practice rights, quoted in J. W. Grove, *op. cit.*, p. 278.

monopolistic status and other prerogatives. This is apt to produce a number of unfortunate attitudes during a period — for example, the last 30-40 years — when the explosive development of medical science and technology called for radical changes in the tools by which scientific insight should be spelled out in health services for individuals, special groups of individuals, and whole populations. This holds true for medical institutions as well as for the activities of the individual doctor

The costs of health services in most countries are increasing at a higher rate than the rise in national income. Under these circumstances the rational and effective use of the many types of medical and paramedical personnel and of medical institutions is becoming an urgent matter. The medical profession has demonstrated relatively little interest in these and other administrative, or should we rather say functional, aspects of the health services.

By leaving these tasks to others, by resisting in many countries the introduction of prepaid medical care and broader health programs, by refusing to consider seriously a new role in the medical team, and also by using their "seller's market" to create inflation in the costs of health services, the medical profession is to some extent putting brakes on the organic growth of measures for health control.

The medical profession has reached a crossroad where a choice has to be made: should the medical doctor be regarded in the traditional way as a "free-lance" or as an integrated part of the total social structure?

New terms such as "medical sociology" or "sociological public health" point to the direction in which we have to move, whether we like it or not. It would be a tragedy if the medical profession, bound by traditional pride and fears, should forfeit its natural, fundamental role in this dynamic process, which will under any circumstances continue rapidly to change the health status and health problems of the world population.¹²³

The implications of this view are many. We will return to more extensive consideration of these important matters in Volume 3 of this Report.

¹²³K. Evang, "Political, National, and Traditional Limitations to Health Control", *Health of Mankind*, Ciba Foundation 100th Symposium, pp. 209-211.

Appendix to Chapter 8

Homeopathy

Homeopathy is not a separate school of medicine, but is a specialized study of drugs. Homeopaths believe that many of the drugs employed by physicians are harmful to the human body and that only those drugs which have been approved according to the standards of Homeopathic Pharmacopoeia should be administered to a patient.¹²⁴

Homeopathy was discovered in the late eighteenth century by Samuel Hahnemann of Saxony who had become a physician in the orthodox way and then became disillusioned with what he considered to be the inefficiency of the orthodox medicine of his time. He attempted to discover safer means of curing diseases. There were three main principles to Hahnemann's theory of drugs. The first was based on the centuries old "like cures like" phenomenon which he explained as follows: a drug producing symptoms similar to symptoms of the disease he was treating precipitated an "antagonistic fever" which counteracted the *ague present*.¹²⁵ This idea bears some resemblance to the modern day principle of immunization. The second aspect of his theory was that decrease in the amount of drugs used in a dose did not necessarily decrease their effect, in fact, it seemed to increase their potency. The third principle was that the individual patient should be treated according to his particular needs rather than according to rigid rules applied to broad categories of disease.

In the nineteenth century, homeopaths came under attack from practitioners of orthodox medicine and were also attacked by chemists who foresaw financial ruin if homeopathy spread. France was the first country in which homeopathy was accepted, and it was introduced to England in 1827 where it received some encouragement from members of the aristocracy. A female homeopath was recently appointed by Queen Elizabeth II as one of her three court physicians.

All of the drugs used by homeopaths are tested carefully and are derivations of some natural product. Homeopaths are opposed to the habit of many physicians today who prescribe to their patient the latest drug made known to them for a specific ailment by the pharmaceutical company who manufactures it.

The main reason that homeopathy has not achieved more recognition from orthodox medicine in the twentieth century is that there has been no proof of its

¹²⁴Homeopathic Laymen's League, *Brief to the Committee on the Healing Arts*, 1967, p. 3.

¹²⁵Brian Inglis, *Fringe Medicine*, Faber and Faber, London, 1964, p. 75.

validity according to tests acceptable to the medical statistician. An Act of Parliament in Britain in 1950 established homeopathy as part of the National Health Service, but to be eligible for practice under the N.H.S. the homeopath must first be trained in a medical school before taking one or two years' special training in one of the six homeopathic hospitals operating in Britain.¹²⁶ In the United States there is also a postgraduate course available during the summer months sponsored by the American Foundation of Homeopathy in Pennsylvania.¹²⁷ Few persons in either Britain or North America are willing to complete this expensive and time-consuming training, particularly since the financial rewards are not as great as in other specialties. Even in England the existing 100 homeopaths represent only one-quarter of the number who were practising in Britain before World War II.

There are currently six homeopathic physicians practising in Ontario and they are all licensed as medical physicians with the College of Physicians and Surgeons of Ontario. Most of these homeopaths have been in practice for many years, and there have been no additions to their numbers in the past decade. Until 1960 the Medical Act of Ontario made provision for representation of homeopathy on the Council of the College of Physicians and Surgeons. When the representative for several years prior to 1960 died, he was not replaced on the Council, and consequently the representation ceased.¹²⁸

There is an organization in Ontario called the Homeopathic Laymen's League in Ontario which consists of twelve to fifteen individuals striving to promote homeopathy in Ontario. There is only one store in Ontario selling homeopathic remedies, and up until 1967 it had been a registered pharmacy. When the aging owner of the pharmacy could find no qualified assistant to dispense prescription remedies, and until 1967 it had been a registered pharmacy. When the aging remedies.¹²⁹

The actual demand for homeopathic services is far from sufficient to warrant having courses established within the medical schools in Ontario. Nevertheless, homeopaths who have received special training in Britain or the United States, and have complied with the standards of the College of Physicians and Surgeons of Ontario, should be permitted to continue their special practice in this province.

¹²⁶Homeopathic Laymen's League, Brief to the Committee on the Healing Arts, 1967, Appendix.

¹²⁷*Prevention*, February 1969, Vol. 21, No. 2.

¹²⁸Homeopathic Laymen's League, Transcript of the Hearings of the Committee on the Healing Arts, October 2, 1967, p. 6349.

¹²⁹*Ibid.*, p. 6342.

Chapter 9 Dentists and Dental Care Personnel

Dental disease is one of the most prevalent forms of ill health. Throughout human history man has experienced the pain and inconvenience of decaying teeth, diseased tissues surrounding the teeth, faulty positioning of the teeth, and eventual loss of teeth. Dental caries, periodontal disease, malocclusion, and edentulism are still the principal ailments treated, and to some extent prevented, by dentists and their auxiliaries.

As it did for most other disciplines, the Committee commissioned a study of dentistry in Ontario. Professor R. K. House of the Department of Economics, York University, undertook the study, which is published as a separate volume. Reference is made to the study throughout this chapter.

Until the 1850's dental treatment consisted of extraction or the application of folk remedies to relieve the pain of dental disease. Practitioners learned their craft by apprenticing and in Western Europe guild organizations were formed for the purpose of regulating entry to the occupation, establishing prices, and enforcing standards of practice. Although it was often associated with general "medical" practice in this early period, dentistry subsequently developed along a separate course in most western countries. This was especially so after new techniques developed during the second half of the nineteenth century made possible restoration of diseased and replacement of missing teeth. Especially in America, dentistry came to emphasize the application of the mechanical skills needed for using vulcanite, amalgam and gold foil to restore teeth. But it was not until the present century that dentists became much interested in the biological and medical aspects of dental disease, an interest which subsequently led to the modern concern with prevention and early correction of decay or malformation, especially in children's teeth.¹

These developments in the practice were accompanied by changes in the education and organization of practitioners. The establishing of dental schools in North America coincided with the development of repair and replacement techniques in the latter half of the nineteenth century, as did the movement to make dentistry a respectable and self-governing profession. By 1900 the latter effort had succeeded to the extent that dental schools were becoming affiliated with universities and dentists were acquiring a social status comparable to that of physicians.

¹K. J. Paynter, *Dental Education in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, pp. 3-4.

History and Organization of the Profession in Ontario

The early dentists in Upper Canada were itinerants who travelled about the country pulling teeth and, not infrequently, at the same time practising other trades to make a living. A few resident full-time dentists are known to have established practices in some of the larger settlements by the 1830's. The skills, equipment, and ethics of these early dentists were far from uniform, for there was no regulation or organization of the practice. Free enterprise prevailed; obstacles to entry into the occupation were few; those who had training in the work obtained it by casual apprenticeship; and competition among practitioners appears to have been spirited. Secret methods, imaginative advertising and price competition were established means of attracting customers.²

After the middle of the century, a few resident dentists in Upper Canada attempted to organize for the purpose of regulating the practice of dentistry, but they made little headway until the late 1860's. In 1867 a small group meeting in Toronto formed the Ontario Dental Association. One of its first acts was to devise membership requirements to exclude itinerant dentists.³ It also promptly set about framing a Bill to present to the new provincial Legislature, a Bill which would create a provincial licensing body responsible for regulating the practice of dentistry in Ontario.

The following year, in 1868, the provincial Legislature passed "An Act Respecting Dentistry".⁴ This was probably the first comprehensive act to regulate the practice of dentistry, and it subsequently served as a model for similar acts in other Canadian provinces and in a number of jurisdictions outside Canada.

The important provisions of the Act were that it incorporated a Royal College of Dental Surgeons and delegated to its Board authority to establish and conduct a dental school in Toronto, to appoint teachers, and to determine the curriculum of studies to be pursued by the students. The Board also was made responsible for licensing and disciplining dentists; and it was given the power to make rules, regulations and by-laws governing its own conduct, subject to the Lieutenant Governor's cancellation or annulment. These powers remain in effect today.

The Board of the College consists of eleven elected members, each of whom is a member of the College and holds office for two years, and the Ministers of Education and of Health who are members *ex officio*. Nine of the elected members are elected by all dentists licensed to practise in Ontario, and one is elected by and from the faculty of each university giving degrees in dentistry. Policies are suggested to the Board through a system of committees: three "statutory committees", whose responsibilities are specified in the Dentistry Act,⁵ and six standing committees. The three statutory committees are the complaints committee, which

²See Ontario Dental Association, *The First 100 Years*, Toronto, 1967, p. 7.

³*Ibid.*, p. 9.

⁴(1868) 31 Vic., c. 37.

⁵R.S.O. 1960, c. 91, s. 8(4) and 25, and S.O. 1965, c. 38, s. 11.

mediates disputes arising between dentists and their patients; the discipline committee, which investigates more serious issues that become the subject of an inquiry; and the executive committee.

The standing committees are concerned with continuing education, dental services, finance, government and legislation, property, and registration and licensure.⁶

The Board's responsibility for dental education is clearly related to its licensing function, but important changes have occurred in the Board's responsibilities in the field of education over the years. Under authority of the Act of 1868, the Board immediately established a dental school in Toronto, although it was not until about 1875 that the school became fully operational. In 1888 the School of Dentistry became affiliated with the University of Toronto.

As dentistry developed into a more scientific discipline the Board found it increasingly difficult to maintain adequate educational standards in its own school. As a way out of the problem, it turned the education of dentists over to the university and in 1925 the School of Dentistry was absorbed into the university as a normal university faculty. The University of Toronto Faculty of Dentistry remained the sole educational facility for preparing dentists in Ontario until 1964, when a second faculty of dentistry was established in the University of Western Ontario. The faculty at Western enrolled its first students in September 1966.

Since 1925, then, dental education (including the education of dental hygienists) has been a university function. The formal authority of the Board over education was left on the statute books, however, and the Board is still formally authorized to determine the curriculum of studies, to set entrance requirements, and to discipline students.⁷ In practice, its activity in the field of education has come to be limited to providing support for some continuing education for dentists, sponsoring extramural lectures and clinics, providing library facilities, supporting public health education, and making certain grants and scholarships available to students.⁸

With the development of the faculty of dentistry at the University of Toronto, three bodies came to be involved in the organization of the dental profession in Ontario: the Ontario Dental Association, the Royal College of Dental Surgeons of Ontario, and the university. Another organization with which both the Ontario Dental Association and the Royal College of Dental Surgeons of Ontario are affiliated is the Canadian Dental Association.

The Canadian Dental Association was formed in 1902 as a "voluntary meeting of dentists" and incorporated in 1942 by an Act of Parliament. One of its

⁶Royal College of Dental Surgeons of Ontario, reply to Questionnaire "A", Committee on the Healing Arts.

⁷Royal College of Dental Surgeons of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 2.

⁸*Ibid.*, pp. 3-4.

declared objects is "To cultivate and promote the art and science of dentistry . . . and to maintain the honour and interests of the dental profession".⁹

The interrelationships among these four organizations are complex. Even members of the profession may be confused as to the respective functions of the Ontario Dental Association, the Royal College of Dental Surgeons of Ontario, the Canadian Dental Association, and the university faculties of dentistry. Yet another body, the Royal College of Dentists of Canada, was added to this list in 1965. It is a national organization established for the purpose of promoting and recognizing certain specialties in dental practice.¹⁰

One major source of confusion in the organization of dentistry has been the extent to which the Royal College of Dental Surgeons came to assume many of the functions of a voluntary professional association, functions which might have been expected to remain with the Ontario Dental Association.¹¹ Although the purpose of creating the College was to promote the "public interest" in dentistry, only members of the profession could stand for election to the Board of the College. Thus, it was natural that the Board should come to be regarded as, and to function as, the governing body of the dental profession in Ontario.¹² The dominant role of the College in this regard was strengthened by its ability to raise funds through a compulsory licensing fee levied on dentists in the province.

Concern within the profession over the respective roles of the Council and the Association, and dissatisfaction with the individual dentist's inability to influence policy in the profession, led the two bodies in 1961 to commission a study of "the organizational structure of the dental profession in Ontario". The resulting report, published in 1964, proposed that the College should relinquish to the Association responsibility for everything except education and regulation of the profession.¹³ It also proposed a change in the relationships between the College, the Ontario Association, and the Canadian Dental Association.

The Canadian Dental Association is a national association of dentists governed by a Board comprising delegates chosen by ten provincial dental organizations. In most cases these provincial "corporate members" are the provincial statutory licensing boards. Ontario has been unique, however, in having both the College of Dental Surgeons and a dental association. Until 1967 the College was the corporate member for Ontario of the Canadian Dental Association. Members of the profession in Ontario were required to pay an annual licensing fee of \$125 to the Royal College of Dental Surgeons. The College then passed on forty dollars of this to the Canadian Dental Association and fifty dollars to the Ontario Dental

⁹Canadian Dental Association, reply to Questionnaire "B", Committee on the Healing Arts.

¹⁰See p. 120 for further reference to this body.

¹¹At one time the Ontario Dental Association was known as the Ontario Dental Society.

¹²R. K. House, *Dentistry in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 147.

¹³See Ontario Dental Association, *Journal*, Vol. 41, April 1964.

Association. Thus, the licensing body in effect served to require members of the profession to support the "voluntary" professional associations through a form of "compulsory check-off".

In 1967 the Ontario Dental Association replaced the Royal College of Dental Surgeons as the corporate member of the Canadian Dental Association. However, the transfer of fees from one organization to another continues. In order to be licensed, an Ontario dentist now pays \$125 per year to the Royal College of Dental Surgeons. Of this, the College retains only thirty-five for its own purposes, turning over ninety dollars to the Ontario Dental Association. The latter, in turn, retains thirty-five dollars, passes on fifteen dollars to the local dental society to which the particular dentist belongs, and pays the remaining forty dollars to the Canadian Dental Association as its corporate membership fee.

The Committee feels that this kind of arrangement is inappropriate, in that it confuses the roles of the voluntary association and the statutory licensing body. The latter, it is believed, should be devoted unambiguously to protecting the public interest in dentistry, without becoming involved in supporting a voluntary association of members of the profession itself.

Recommendation:

- 28** That the Royal College of Dental Surgeons of Ontario discontinue the practice of making grants from licensing fees collected by it either to the Ontario Dental Association or to the Canadian Dental Association, that the voluntary nature of these latter two professional organizations be recognized by elimination of its being a condition of receiving a licence that a dentist be a member of, or financially support, either of these two associations.

A relatively recent development in the organization of the dental profession has been the development and recognition of specialist qualifications. While the certification and licensure of specialists in dentistry has always been one of the responsibilities of provincial licensing bodies in Canada, there has been little uniformity or consistency in these provisions from one province to another. Requirements for specialist certification have varied, as have the definitions of the specialties themselves. The traditional specialties recognized by the Canadian Dental Association for many years were oral surgery, orthodontics (prevention and correction of irregularities of teeth) and periodontics (care of the gums). In 1965 the specialties of paedodontics (care of children's dental problems) and prosthodontics (making and fitting artificial teeth and other appliances for the mouth) were recognized. Yet in some provinces as many as seven specialties have been recognized.¹⁴

The Canadian Dental Association worked for several years to promote the establishment of a national body to establish a uniform set of qualifications for

¹⁴Information provided by Royal College of Dentists of Canada.

dental specialties, and to designate qualified specialists. In 1965 Parliament enacted legislation to incorporate a Royal College of Dentists of Canada to perform these functions.¹⁵ The new body determines who is acceptable for specialist certification and eventual "Fellowship" in the College by means of examinations, and then it recommends successful candidates to the provincial licensing boards concerned who retain the right to license specialists in their own areas. It does not determine the specialties to be recognized; this remains a function of the Canadian Dental Association which continues as the policy-making body for the profession in Canada. The first Fellowships granted by the College were Charter Fellowships awarded to seventy-nine specialists selected by the Council of the College for having given evidence in ten years or more of practice of having "high ability in one of the branches of dentistry recognized as specialties by the Canadian Dental Association".¹⁶

The Practice of Dentistry Today

There were some 2,732 dentists licensed to practise in Ontario in 1967. Of these probably about 10 per cent were not actively practising their profession; thus there are probably about 2,500 active dentists. These employ over 4,000 ancillary workers — secretary-receptionists, chairside assistants and dental hygienists. They also employ (now indirectly, as a rule, through commercial dental laboratories) several hundred dental technicians who manufacture dentures and other dental prosthetic devices.¹⁷

A small proportion of all dentists practising in the province are "specialists" insofar as they limit their practices to oral surgery, orthodontics, paedodontics or periodontics. In 1968 there were in total 178 of these specialist practices, most of them clustered in the large urban centres of the province.¹⁸

Despite the emergence of these specialist practices, most of the modern practice of dentistry is still devoted to routine repair and replacement of decayed teeth, prescription and fitting of dentures, and the treatment of common periodontal disease. While preventive practices — including the teaching of oral hygiene, early treatment of disease in childhood, improved nutrition, and fluoridation of water supplies — have improved the dental health of the population in recent decades, dental disease remains endemic. Most dentists continue to earn their living by performing repair work and fitting artificial teeth for the approximately one-third of the population that elects to have such work done. Improved materials, better equipment, new techniques, and the greater use of trained assistants have raised the quality of dental care and increased the productivity of dentists in recent decades, but there have been no great changes in the practice of dentistry comparable to those which have revolutionized medical practice.

¹⁵Statutes of Canada, 13-14, Eliz. II, c. 80.

¹⁶*Ibid.* s. 6(1).

¹⁷R. K. House, *op. cit.*, p. 2.

¹⁸See Chapter 6, Table 6.28.

The way in which dental care is provided has changed little since the itinerant dentists of the first half of the nineteenth century were displaced by resident dentists working in their independent, individual offices over the local bank or hardware store. Such private, largely self-contained practices remain the normal arrangement for bringing patient and dental care together. School clinics, travelling clinics (such as the Red Cross and Ontario government railway cars operated in northern Ontario), industrial clinics, and a few hospital dental departments supplement, but do not seriously rival, the traditional private office practice.

The method of payment for dental services is almost entirely fee for service. Of all the health care occupations dentistry is the pre-eminent example of independent practice. Few dentists are salaried employees and although various kinds of "combined practices" are common enough, most dentists are still engaged in solo practice.¹⁹ Consequently, the practice of dentistry is highly decentralized. In dentistry, this decentralization is not offset, as it is in the case of medicine, by reliance upon hospitals or other central institutions required for the treatment of patients. Individual dental offices are typically equipped with the machinery and personnel required for all but the most unusual work done by dentists. The principal exception to this is in the manufacture of artificial teeth, which is now usually entrusted to an outside dental laboratory.

This independence and decentralization of dental practitioners has several important implications for the education and regulation of dentistry discussed later in this chapter. Because they are so independent, dentists may find it relatively difficult to keep up with the development of dental technology, and they may not be as exposed to the kind of external quality controls that physicians experience.²⁰

Combined practices can overcome some of these scale disadvantages, often without much reducing the individual dentist's independence. In some combined practices a dentist may employ another dentist, perhaps a recent graduate, and pay him a wage or commission. Or two or more dentists may enter into a cost-sharing agreement whereby they retain their own patients but make common use of an office and other facilities. Sometimes dentists will form more formal partnerships involving sharing not only of costs, but of revenues from the practice.²¹ Of particular interest is the effect these different kinds of arrangements appear to have on the use of auxiliary personnel in private dental practice. The employment of such workers increases markedly as we move from the extreme of the completely independent solo practitioner, through the cost-sharing arrangement, to the partnership.

¹⁹See O. Hall, *The Utilization of Dentists*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, Ch. 3. Hall reported that even among those dentists engaged in some form of combined practice in Canada, only 18 per cent shared space, facilities and patients with colleagues.

²⁰R. K. House, *op. cit.*, pp. 68, 70.

²¹*Ibid.*, p. 79.

The ancillary personnel employed in private dental practices in Ontario may be classified as dental nurses and assistants, dental technicians, and dental hygienists. Dental nurses and assistants are part of an ill-defined group which includes various kinds of "secretary-receptionists" (although this term usually refers to the dentist's chairside assistants). Over 90 per cent of dentists in Ontario employ an assistant, at least on a part-time basis. Over 70 per cent employ a full-time assistant.²² There is much evidence to suggest that these dental auxiliaries make a large contribution to the "productivity" of a dental practice. It also appears that in the relatively few practices employing more than one dental assistant, the effectiveness of these workers does not diminish as more are employed. There is reason to believe that as many as five assistants may be employed by a dentist in a sufficiently large practice without there being a marked reduction in return relative to cost.²³ However, where there are five assistants it is likely that one of them is actually another dentist.

Secretary-receptionists and chairside dental assistants require relatively low levels of education and training. Because of this, and the fact that they are female, wages tend to be correspondingly low. Some dental assistants do receive formal training for their job by attending courses sponsored by the Ontario College of Dental Surgeons and, more recently, offered by the Colleges of Applied Arts and Technology. Certification of dental assistants who have successfully completed such a course is provided by a voluntary organization, the Ontario Dental Nurses and Assistants Association.

A "dental technician" is defined in section 1(b) of the Dental Technicians Act as "a person upon the prescription or orders of legally qualified dentists or physicians makes, produces, reproduces, constructs, furnishes, supplies, or alters or repairs any prosthetic denture, bridge, appliances or thing to be used in, upon, or in connection with a human tooth, jaw or associated structure or tissue, or in the treatment of any condition thereof".²⁴ A dental technician in Ontario may be certified under the Dental Technicians Act, and only persons so certified may be known as "Registered Dental Technicians". Conditions for certification include having a minimum of four years of employment by a dentist or registered dental technician and passing an examination administered by the Governing Board of Dental Technicians of the Province of Ontario. Until recently all dental technicians learned their trade in Ontario by informal apprenticeship in a dentist's office or more commonly in a commercial dental laboratory. Now there are available both a two-year and a three-year course of formal training provided for dental technicians in at least one College of Applied Arts and Technology.²⁵ Not all the technicians employed in dental laboratories are registered dental techni-

²²*Ibid.*, p. 26.

²³*Ibid.*, pp. 29-31.

²⁴R.S.O. 1960, c. 90, s. 1(b).

²⁵Governing Board of Dental Technicians of the Province of Ontario, reply to Questionnaire "A", Committee on the Healing Arts, Appendix B.

cians; indeed, most are not. One of the motives for such workers to obtain such status is the requirement that only registered dental technicians may own or operate a dental laboratory business in Ontario.

"Dental hygienists" are a relatively new type of dental auxiliary in Canada. Hygienists are legally authorized (under the provisions of the Ontario Dentistry Act) to perform under the direct supervision of a member of the Royal College of Dental Surgeons ". . . the services of cleaning and polishing teeth and the giving of instructions and demonstrations in oral hygiene and mouth care . . ." and other "specific dental duties of a minor character" which may be delegated to them under the regulations of the College.²⁶

The education of dental hygienists is provided by the Faculty of Dentistry in the University of Toronto through a two-year course of studies leading to a Diploma in Dental Hygiene. The diploma is accepted by the College of Dental Surgeons as evidence of qualification for licensing as a dental hygienist. A voluntary organization, the Ontario Dental Hygienist Association was established in 1963.

All these ancillary workers — the secretaries, dental assistants, technicians and hygienists — make an important contribution to the quantity and quality of dental services available in Ontario today. But none of them is an alternative or substitute for dentists. Even the technicians who have taken over most of the making and repair of prosthetic devices from the dentists themselves work only through a practising dentist, being explicitly forbidden by law to deal directly with patients. The dental hygienists do perform services directly for patients; but under existing arrangements, this work can be done only under the direction and supervision of a dentist. By freeing the dentist from this and other routine work, the productivity of individual dental practices has undoubtedly been increased.

Many proposals have been made for enlarging the roles of these existing categories of dental workers in order to increase the quantity and to decrease the cost of dental care in the community. The dental technicians, for example, conceivably could be allowed to deal directly with the public to repair or even to devise the dental prosthetics which they now only manufacture. This, however, is strongly opposed by dentists on the grounds that technicians lack the knowledge of anatomy, physiology and other basic sciences required to do this work safely for the patient. Dental hygienists, it has also been suggested, could be trained to perform many more tasks than they presently are allowed to do.²⁷

An even more direct proposal of this kind was made by the Royal Commission on Health Services in 1964, which recommended that a new type of dental auxiliary, to be trained through a two-year program, be authorized to prepare cavities and place fillings in children's teeth.²⁸

²⁶R.S.O. 1960, c. 91, s. 12.

²⁷Ontario Dental Hygienists Association, Brief to the Committee on the Healing Arts, 1967.

²⁸*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, pp. 76-77.

The principal models for such innovations are the New Zealand dental nurse and the United Kingdom New Cross Auxiliary. Both are intended to provide dental care for children. Although the New Zealand dental nurse is not permitted to set up a private dental practice, she does do work that otherwise would be done by dentists, if it were done at all. Furthermore, she works alone, without direct supervision by a dentist. In contrast, the New Cross Auxiliary is intended to work under a dentist's supervision. Both are trained in two calendar year courses, not much longer than the Ontario dental hygienist receives.²⁹ Because of the shortness of the training period required to bring such dental workers up to the level of skill required to perform satisfactory routine repair and preventive work in dentistry, a case can be made for encouraging the development of such a class of dental worker in situations where the demand for dental care cannot be met economically by training sufficient numbers of fully qualified dentists. Whether or not this condition exists in Ontario is considered later in this chapter.³⁰ We may note here, however, that the dental profession in Ontario has shown no enthusiasm for such proposals. Even the use of dental hygienists has been discouraged both by the imposition of very high educational requirements for hygienists and by a rule of the College of Dental Surgeons stipulating that "a member may employ one dental hygienist only . . .".³¹ Although the number of available dental hygienists is increasing steadily, the relatively limited extent of their contribution to the supply of dental services available in the province may be suggested by the fact that in 1967, only 5.35 per cent of the dentists practising in Ontario employed a full-time hygienist. Another 7.53 per cent employed a hygienist on a part-time basis.³² Most of the available hygienists tend to be concentrated in urban areas.³³

Recommendations:

- 29 That the dental hygienist be recognized as an important member of the dental care team, and that existing university diploma programs be expanded to increase the number of hygienists trained.
- 30 That there should be no restriction regarding the number of hygienists that may be employed by a dentist, and that the Royal College of Dental Surgeons be required to repeal its by-laws imposing such a restriction.

Taking into account on the one hand the recommendations of the Royal Commission on Health Services supporting the introduction of the dental assistant, and on the other the opposition to such a measure of the dental profession in Ontario, we have not made a specific recommendation regarding the introduction of such an assistant at this time. But as there may well be definite benefits to the

²⁹K. J. Paynter, *op. cit.*, pp. 80-81.

³⁰See p. 134.

³¹Royal College of Dental Surgeons of Ontario, By-laws, Article XIV, Section 10 (d).

³²R. K. House, *op. cit.*, Table 5, p. 27.

³³*Ibid.*, p. 42.

employment of such auxiliaries, as indicated by the experience of the New Zealand and British programs, we feel this matter should be pursued. A careful assessment of the results of existing programs in other jurisdictions should be undertaken and their applicability to the Ontario situation studied. If the introduction of such an auxiliary is undertaken, it is our view that there need not first be a pilot project, and that the implementation might be proceeded with directly.

Recommendation:

- 31** That the Ontario Council of Health examine the possible utilization of the dental nurse along the lines of the New Zealand or English type and report its findings to the Department of Health with recommendations for specific measures.

Specialization in Dental Practice

Reference has been made above to the various dental specialties which have evolved and to the recent establishment of a national body, the Royal College of Dentists of Canada, to establish uniformity in the recognition and regulation of these specialties across Canada. In Ontario five specialty branches of dentistry are currently recognized by the Royal College of Dental Surgeons: orthodontics, oral surgery, periodontics, paedodontics, and dental public health. A small proportion of dentists (about 6 per cent in 1968) are engaged in specialty practice.³⁴ Because they are concentrated in a few large urban centres, the services of these specialists are not readily available to a very large part of the population. Such a geographical maldistribution of dental specialist services seems particularly harmful in the cases of those particular specialties — paedodontics and orthodontics — which bear directly upon the dental health of children. Although a number of sound explanations may be found for the scarcity of such specialists, notably the limited ability of rural areas to support specialized practitioners and the limited capacity of existing graduate training facilities, it is also likely that some of the causes of this situation are unnecessary. In particular, it appears that the availability of specialist services is partly limited by the policies of the College of Dental Surgeons of Ontario with regard to specialty practice. Section 14 of Article XIV of the College's By-laws stipulates that:

Every member of the College receiving a licence to practise as a specialist must, as a condition of qualification, limit his practice of that specialty to the exclusion of general practice.

The purpose of this provision appears to be to encourage general dentists to refer their patients to specialists, as required, without fear that the specialist will take over the patient. However serious such a problem may be, the provision has the further consequence of discouraging a dentist with specialist qualifications from establishing his practice in an area where the demand would not support a

³⁴See Chapter 6. Compare Table 6.28 with Table 6.24.

purely specialist practice. The Committee does not believe that such matters as this should be allowed to contribute to the difficulty of achieving a better distribution of scarce health resources in the province.

Recommendation:

- 32** That the Royal College of Dental Surgeons be required to abolish its restrictions on the practice of dental specialists that prevent them from practising general dentistry.

We recognize that such a change may create problems with respect to referrals or lack of them, but it is hoped that an awareness of public responsibility on the part of the dental profession would ensure that referrals are made when required and that this is a matter to be worked out by the profession. Removal of such restrictions, it is hoped, would also encourage specialists to set up practices outside Metropolitan Toronto, since they would then be able to practise both their own specialty and general dentistry as required in order to develop an adequate practice.

Another aspect of the present practice of dentistry of particular interest is the relationship between dentists and hospitals. The independence of the typical practitioner has already been remarked upon, and we have noted how this is related to the extent to which he has been able to provide himself with an "operatory" sufficiently well equipped to meet his needs for treating his patients. In this respect the dentist is most unlike the physician who, as we have seen,³⁵ has typically become highly dependent upon hospitals to provide facilities he requires. There are, however, situations in which dentists, and particularly dental specialists, must also make use of hospital facilities in the course of their work.

The availability of hospital facilities to dentists and the arrangements under which dentists work in hospitals are not simple matters to define. Many hospitals, especially the larger urban ones, provide dental services, but these vary greatly in quantity and accessibility to the public. Most of these hospital services appear to be intended primarily to meet the dental needs of patients in the hospital, and very few of them meet the standards set by the Canadian Dental Association in regard to the adequacy of such facilities.³⁶ One reason for this traditional lack of well-organized dental departments or clinics in hospitals may be that until recently there was little interest in or need for such facilities. We have heard, for example, that it is only in recent years that dentists have begun to believe that work requiring general anaesthetics should be done in hospitals rather than in their own offices.³⁷ It also appears that until they were amended in 1966, the regu-

³⁵See Chapters 8 and 27.

³⁶B. A. McFarlane, *Dental Manpower in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, pp. 103-104.

³⁷Canadian Dental Association, Transcript of the Hearings of the Committee on the Healing Arts, April 3, 1967, pp. 2049-2050.

lations made under the Public Hospitals Act tended to make it difficult to establish dental departments in hospitals.³⁸

A further factor which we believe has caused some hospitals to be slow to provide dental facilities or to invite dentists to associate themselves with the hospital is a jurisdictional conflict between oral surgeons who are dental specialists and plastic surgeons who are surgical specialists. This arises in its most acute form from an overlapping of the work done by a few dentists who are specialists in oral surgery and surgeons who are specialists in plastic surgery. To the extent that plastic surgeons have wished to keep oral surgeons from becoming involved in cases involving jaw fractures, and to the extent that they and their colleagues have been able to influence hospital policy, it may be that some hospitals have not been as enterprising in developing dental departments as they might otherwise have been.³⁹ The position of the medical profession on this point was made clear to the Committee in a submission made by the Ontario Medical Association. In its view:

The patient must continue to be the responsibility of a medical practitioner who is capable of taking care of the whole patient.⁴⁰

From this general position, the Ontario Medical Association has argued that "oral surgery, like other surgical specialties, should be under the supervision of the Director of the Department of Surgery."⁴¹ It has also expressed the opinion that oral surgeons are now allowed to undertake too many procedures under Regulation 10 of the Medical Services Insurance Act.⁴²

The matter of dental practice in hospitals has been further complicated by the spread of hospital insurance coverage in the province. This has meant that patients requiring multiple extractions, for example, may now be given hospital care and associated services without direct cost to them. Further, some dental work itself may be covered by such insurance if it is done in hospital, but not if it is done in the dental office outside.

The Committee is of the opinion that further development of hospital dental practice should be encouraged and that arrangements which have the effect of preventing dentists from using hospital facilities for the treatment of their patients are unwarranted. In particular, the requirements that make it impossible for hospitals to confer admitting privileges on dentists should be eliminated.

Recommendations:

- 33** That the regulations under the Public Hospitals Act be amended to require that qualified dentists, particularly in dental specialties, should have access to the use of hospital facilities as required for procedures

³⁸*Ibid.*, p. 2045.

³⁹*Ibid.*, pp. 2052-2054.

⁴⁰Ontario Medical Association, Supplementary Brief to the Committee on the Healing Arts, 1968, p. 10.

⁴¹Ontario Medical Association, Brief to the Committee on the Healing Arts, 1967, p. 54.

⁴²*Ibid.*, pp. 52-53.

requiring hospitalization. Dentists should be eligible for full hospital privileges with the right to admit patients and with representation on the Admissions Committee. Dentists should follow the regular hospital procedures and their patients should be subject to the same admission requirements as patients admitted by physicians.

- 34 That in hospitals where there is a large demand for dental services a separate dental department with a Chief of Dental Services be established, and that in other hospitals the dental services should be under the department of surgery.
- 35 That one hospital in Metropolitan Toronto should develop outpatient dental services.
- 36 That every hospital should have one or more dentists as members of the attending staff, preferably including an oral surgeon where possible, to assist the medical staff as required.
- 37 That a qualified dentist should be given the privilege of treating in hospitals his patients requiring dental care while they are hospitalized for other conditions. This would particularly apply to long-term patients, in convalescent and rehabilitation institutions.

The foregoing notwithstanding, the Committee is aware of the danger that a great extension of insurance coverage for dental care in hospitals could lead to hospital facilities being overwhelmed and the established forms of providing this service disrupted unnecessarily. The Committee agrees in general with the present policy (1969) regarding coverage of dental services in hospitals by the Ontario Health Services Insurance Plan.

Recommendation:

- 38 That caution should be exercised to ensure that financial arrangements regarding dental services are such that they do not create an unnecessary demand on hospitals where services could be adequately provided outside the hospital.

It will be apparent from what has been said about the dental facilities provided by hospitals that they offer little scope for the training of dental students. Unlike the medical student, the student of dentistry does not look to the hospital as the obvious source of clinical experience. Instead, clinical aspects of dental education must be provided elsewhere, and the pattern which has emerged is for the schools of dentistry to organize their own clinical teaching facilities. One consequence of this is that the dental student is not much exposed to the hospital environment, and as a result he is unlikely either to feel at home in it or to relate his subsequent practice to it. The education of dentists and their auxiliaries is considered in the next section.

Education

Organization and Control of Dental Education

The present pattern of dental education in Ontario was established in 1925, when the School of Dentistry of the Royal College of Dental Surgeons was made a faculty of the University of Toronto. Although the Board of the College of Dental Surgeons of Ontario thereby delegated dental education to the university, it retained its formal powers over education. The present Dentistry Act still provides that:

The Board may appoint one or more examiners for the matriculation or preliminary examination of all students entering the profession, or may accept in lieu of such matriculation or preliminary examination evidence that a student has passed any other satisfactory examination . . . ,

Such examinations shall be passed before the person concerned is entered as a student of dentistry.⁴³

The Board may prescribe a curriculum of studies to be pursued by students, the examination necessary to be passed and the fees to be paid to the treasurer before a certificate of licence to practise dental surgery is issued.⁴⁴

This arrangement provides a particularly clear illustration of a fundamental issue with which this Committee has had to deal: the relationship between professional licensing bodies and the educational institutions preparing health professionals for practice. The education of dentists in Ontario was assigned by the College to the university because by 1925 it was felt that the advance of knowledge in the basic sciences relevant to the practice of dentistry had reached the point where only a university could provide the kind of faculty and other resources required to teach and effectively to develop such knowledge. In this regard the Royal College of Dental Surgeons has stated that:

From 1875 to 1925, supported by dues of the dentists of Ontario, the Board maintained the School of Dentistry of the Royal College of Dental Surgeons, a college that enjoyed world wide recognition as one of the leading dental colleges in the world. However, by 1925 the expansion of knowledge and the need for research made the burden so heavy that it was no longer economically feasible for the profession to maintain the necessary standards.⁴⁵

Dentistry, it was believed, had accumulated a body of knowledge which could be transmitted and expanded only within the special environment of the university. Apparently dentists no longer believed that their practice could rely upon technical knowledge, with whatever smattering of biological and other scientific knowledge they required being acquired through a few classes provided by convenient universities or through visiting professors of these subjects. Rather than attempt to bring

⁴³R.S.O. 1960, c. 91, s. 13.

⁴⁴*Ibid.*, s. 14(1).

⁴⁵Royal College of Dental Surgeons of Ontario, Brief to the Committee on the Healing Arts, 1966, p. 2.

science into the dental school, the dental school, with its program of technical and clinical training, was moved into the university. The significance of this must not be overlooked. As Dean Paynter has pointed out,

. . . the functions of a university . . . remain basically two-fold, the acquisition of new knowledge through research and the transmission of knowledge by teaching. All activities that are related to either of these functions properly belong in a university. Those not related to the two functions should not be university responsibilities.⁴⁶

This is not to say that "technical" elements of dentistry or other professions are not or should not be taught in universities. They are and will continue to be, if for no other reason than that they cannot be easily disentangled. As the calendar of the University of Toronto Faculty of Dentistry notes with regard to the present program of dental studies, "The dental course is designed to unify the cultural subjects, fundamental sciences and dental studies, as it is believed that cultural, scientific and professional development cannot be sharply differentiated . . ." ⁴⁷ Yet the primary concern of universities is with the discovery, preservation, and passing on of knowledge, not with the training of workers to meet the specifications set by members of particular occupations for admission to their ranks. Therefore, the emphasis of a course of studies in a university will be "academic" rather than "technical". This seems to be acknowledged by the declaration of the new faculty at the University of Western Ontario that its objectives are "to select students who are intellectually, morally, and physically qualified for a career in dentistry and to provide them with an *academic* environment conducive to a broad education including the acquisition of the special knowledge and skills of dentistry".⁴⁸

It appears to be clear from these statements that placing the education of dentists in the universities reflects a judgment as to the relative importance of the academic and the "mechanical" aspects of this discipline. The imparting of dental skills is seen as part of a larger body of education.

University faculties of dentistry have in the past been criticized for doing too little research and otherwise neglecting their more strictly academic responsibilities. Paynter wrote in 1964 of Canadian dental schools generally that, while they were working at training teachers, doing research and training researchers, ". . . there is still a great deal of variation in the degree to which these functions are carried out across the country".⁴⁹ The continuing orientation of dental schools towards meeting the needs of the established profession may be suspected as a major cause of such uncertainty in the "academic" activities of dental faculties.

While a professional body like the Royal College of Dental Surgeons of Ontario may be the best source of judgment concerning the professional com-

⁴⁶K. J. Paynter, *op. cit.*, p. 5.

⁴⁷University of Toronto Faculty of Dentistry, *Calendar 1968-69*, p. 20.

⁴⁸University of Western Ontario, Faculty of Dentistry, *Calendar 1969-70*, p. 16. (Emphasis in original.)

⁴⁹K. J. Paynter, *op. cit.*, p. 7.

petence of a dentist, it is less clear that it is the best body to determine what constitutes a good university education — or, for that matter, the best number and kinds of university graduates in dentistry.

At the same time, it is possible that the academics charged with educating dentists may lose touch with the evolution of the practice of dentistry, or for other reasons neglect “practical” elements of the curriculum. Thus close liaison between academics and practitioners is desirable in this and other professions. It does not appear necessary to this end, however, to confer upon a professional licensing body powers which enable it to determine or even to influence admission requirements and curriculum for a university faculty. Yet such provisions still exist in the Ontario legislation concerning dentistry.

The arrangements, statutory and otherwise which have evolved in Ontario between the University of Toronto, and since 1964 the University of Western Ontario, and the Royal College of Dental Surgeons of Ontario are ambiguous and, in the opinion of the Committee, appear more likely to retard than to advance the development of dental education and practice. If nothing else, they create uncertainty about the role of the profession in influencing the kinds and amounts of dental services available in the community.

Recommendation:

- 39 That the Dentistry Act be amended and section 13 repealed so that the Royal College of Dental Surgeons of Ontario no longer be empowered to establish entrance requirements for dentistry; also that section 14(1) be repealed to remove from the Board of the Royal College of Dental Surgeons of Ontario control over the curriculum of studies.

Another point at which the interests of the professional organization of dentistry may have an influence on the educational institution is through the accreditation of dental schools. Again the question arises as to whether this is desirable. On the one hand it would seem to ensure that the schools would not neglect the practical training aspects of dental education, those needs most likely to be foremost in the minds of well-established practitioners. On the other, it may discourage innovation and development in the discipline. Evidence concerning these effects in the past is difficult to find and to interpret. But it does seem that dentistry has been slow to adapt to changing technology and changing social needs and conditions. The paucity of research, the slow development of graduate specialty programs, and the relative neglect of social and public health aspects of dentistry have all been noted even in sympathetic studies of dental education in Canada.⁵⁰ In particular the relative weakening of graduate programs in dentistry compared to other university disciplines suggests that a strengthening of the academic rather than of the “practical” offerings of dental schools is required in

⁵⁰See K. J. Paynter, *op. cit.*, and R. K. House, *op. cit.*

the future. Because of this, it seems desirable that the accreditation of dental schools for undergraduate and particularly for graduate education in dentistry should be entrusted to "educational" rather than "professional" bodies.

Until recently, the accreditation of dental schools in Canada was neither difficult to provide for nor a very onerous task, given the small number of schools and the relatively infrequent movement of students among them. With the increase in the number of schools, the development of graduate programs, and greater mobility of students, accreditation has become a much more important matter. At the national level the Canadian Dental Association has developed an accreditation procedure administered by its committee on education, known as the Canadian Dental Association Council on Education. This Council consists of six members, three of whom are customarily deans of dental schools.⁵¹ As noted earlier, however, the Canadian Dental Association is a "voluntary" organization representing licensed dentists belonging to the various provincial professional associations and not specialists in dental education.

An academic body which could assume these accrediting functions at the national level is the recently organized Association of Canadian Faculties of Dentistry. This body comprises the deans of all ten Canadian faculties and one member elected by each of these faculties. It is closely linked to other national dental bodies — the National Dental Examining Board, the Canadian Dental Association and the Royal College of Dentists of Canada — through cross-representation on the various executives of these bodies. There appear to have been some discussions concerning the possibility of the Association of Canadian Faculties of Dentistry becoming the accrediting body for Canadian dental schools; and, although no action has been taken in this regard, the Committee believes that this would be a desirable development.

Two further steps which could strengthen the procedures for accrediting dental schools would be to improve their financing and to broaden the bases for establishing relevant and up-to-date criteria. Rather than rely upon the rather uncertain finances of a voluntary organization or payments collected from the institutions being evaluated, it would be desirable to make the meeting of such costs a public responsibility.

With regard to the breadth of judgment and experience brought to bear on the process of evaluating and re-evaluating dental schools, the small number of schools in Canada, and particularly in any one province when accreditation is proceeding at that level, it would seem desirable to give representation on accrediting teams to experts from outside Canada.

Recommendation:

- 40** That accreditation of Canadian dental schools be undertaken by the Association of Canadian Faculties of Dentistry. If, however, this Asso-

⁵¹Canadian Dental Association, reply to Questionnaire "B", Committee on the Healing Arts; also see Constitution and By-laws of the Canadian Dental Association, p. 13.

ciation is unable or unwilling to take on this function the Committee recommends two alternatives. The preferred alternative would be to leave the responsibility for accreditation with the Canadian Dental Association Council on Education. A second alternative would be for the Government of Ontario to direct the Department of University Affairs to establish accreditation teams which would be responsible for accrediting Ontario dental schools. In any of the above programs the Committee recommends that financial contributions to the cost of providing accrediting services in Ontario, if necessary, should be made by the Government of Ontario, and that it would be essential, because of the small number of dental schools in Ontario, that several members of the accrediting team be from outside Canada, particularly the United States.

The Committee is also of the opinion that the accreditation of schools for graduate work in dentistry should also be the function of an academic rather than a professional body.

Recommendation:

- 41 That accreditation of graduate programs in dentistry should also be undertaken by the Association of Canadian Faculties of Dentistry as soon as possible.

Present Educational Facilities and Programs

University Dental Schools

The two university schools of dentistry already referred to provide all the dental education available in Ontario, graduating both dentists and dental hygienists. The University of Toronto Faculty of Dentistry is equipped to accommodate about 650 students and is operating at capacity. The total enrolment in 1966-1967 comprised 500 undergraduate dental students, fifty-eight postgraduate and graduate students of dentistry, and ninety-seven dental hygiene students.⁵² The University of Western Ontario Faculty is not yet in full operation but is being equipped to accommodate fifty-two students in each of four years, seventeen to twenty graduate students in clinical disciplines, and twenty dental hygiene students.⁵³ Both Ontario dental schools offer a similar undergraduate course of four years leading to the degree of Doctor of Dental Surgery. This is the basic dentistry degree recognized by the Royal College of Dental Surgeons of Ontario. The university examinations and results are accepted by the College as fulfilling the requirements for admission to the Licentiate Diploma granted by the College prior to admitting a dentist to practice.

Both the Ontario schools require candidates for admission to the under-

⁵²University of Toronto Faculty of Dentistry, Supplementary Brief to the Committee on the Healing Arts, p. 5.

⁵³University of Western Ontario, Faculty of Dentistry, reply to Questionnaire "C", Committee on the Healing Arts, p. 15.

graduate dentistry program to have completed successfully some previous university work. The Toronto school requires at least one pre-dental year, the school at Western requires two.⁵⁴

In the hearings with the Committee a member of the Dental Faculty at Western stated that they were requiring

. . . a little different admission standards simply because our program is a fundamental integral part of a health sciences centre. . . in the first two years of operation our students are taking some conjoint programs with the Faculty of Medicine and our Faculty believed it was imperative that we provide these basic science departments with students of similar academic preparation for them.⁵⁵

The applicants to the dental school at Western must have completed several specific courses, including organic chemistry, which normally is not offered until the second year of an undergraduate science program. At the University of Toronto, however, the practice has been to offer organic chemistry as part of the curriculum in the first professional year of dentistry. The possibility that an undergraduate degree might be required as a prerequisite for entry to dental school also came to the attention of the Committee.⁵⁶ While endorsing the concept of the health sciences centre and the education of health professionals together where possible, the Committee believes that further lengthening of the entrance requirements is not warranted, and that no changes should be made in the present prerequisites at the existing schools which would delay the student's entry to the professional program. Indeed, we advise that a continuing review be made by the Department of Health and the Ontario Council of Health of the entrance standards for dentistry with an evaluation of the relative advantages of the alternative prerequisite arrangements. Unless the product of the lengthier education process could be shown to display advantages in practice, consideration should be given to maintaining only a one year pre-professional requirement.

Recommendation:

- 42** That the Department of Health and the Ontario Council of Health evaluate the advantages of the various pre-dental educational requirements and that university schools of dentistry require not more than the minimum educational prerequisites necessary to produce a satisfactory practitioner.

In addition to the previous year or years of successful university attendance, the dentistry schools also request applicants to take the dental aptitude tests conducted by the Council on Education of the Canadian Dental Association in cooperation with the American Dental Association. One reason given by dental

⁵⁴University of Toronto, Faculty of Dentistry, *Calendar 1968-69*, p. 21; University of Western Ontario, Faculty of Dentistry, *Calendar 1969-70*, p. 17.

⁵⁵Royal College of Dental Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, April 3, 1967, p. 1898.

⁵⁶Faculty of Dentistry, University of Toronto, Transcript of the Hearings of the Committee on the Healing Arts, April 3, 1967, p. 2012.

schools for this requirement is that with few exceptions all their students enter as freshmen, with the result that failure or withdrawal from the course creates spaces in the class which are not easily filled in the upper years (although such gaps often can be filled by foreign students who may be admitted directly into the upper years). Now that more than one dental school exists in the province, it is also important that admissions procedures be coordinated. The Committee believes that the existing arrangements in this regard could be improved.

Recommendation:

- 43 That the Minister of Health of Ontario request that the Deans of faculties of dentistry in Ontario ensure that information concerning applications for entrance to dental schools in Ontario is properly analyzed and that a centralized application procedure for dentistry be developed, such as that now used for admission to most Arts and Sciences faculties in Ontario.

The curriculum in the undergraduate Doctor of Dental Surgery programs emphasizes the basic sciences taught mainly in the first and second years, and clinical practice, most of which is concentrated in the third and fourth years. The principal science subjects taught are biological: anatomy, biochemistry, bacteriology, histology, pathology, pharmacology and physiology. Most of the clinical experience in these undergraduate programs is provided in the dental schools' own dental clinics rather than in hospital or other "practical dental clinics" outside. Some hospital experience is now provided for University of Toronto undergraduates in dentistry at the Toronto General Hospital, where fourth year students attend the outpatient dental clinic for several days of instruction in hospital dentistry.⁵⁷ Undergraduates at the University of Western Ontario will also receive some hospital experience as part of their fourth year clinical curriculum.⁵⁸

The Committee agrees with the growing interest of dental schools in providing hospital experience for their undergraduates and also in the greater development of public health and preventive aspects of dentistry. These innovations in what has been a relatively rigid and unchanging program of studies⁵⁹ are overdue and, to the extent that it is possible without lengthening the undergraduate course, should be carried even further in order to make it easier for the dentists of the future to fit into the broader health services system which we hope to see emerge. In particular, the Committee feels that in this, as in other branches of the healing arts, much greater attention should be paid to the prevention of disease.

Recommendation:

- 44 That greater emphasis be placed on preventive dentistry in the undergraduate dental curriculum.

⁵⁷Toronto General Hospital, Department of Dentistry, reply to Questionnaire "D", Committee on the Healing Arts.

⁵⁸University of Western Ontario, Faculty of Dentistry, *Calendar 1969-70*, p. 37.

⁵⁹K. J. Paynter, *op. cit.*, p. 53.

The Committee also notes in regard to the undergraduate dental curriculum that although dental hygienists are currently trained in the university dental schools, relatively little attention appears to be given in the dentists' curriculum to impressing upon students the contribution hygienists and other dental auxiliaries can make to dental practice, and especially to the preventive aspects of dentistry.

Recommendation:

- 45 That steps be taken to make dentistry students more aware of the possibilities and usefulness of dental auxiliaries, including their role in preventive dentistry.

The only other observation we would make about the undergraduate curriculum is that it is not possible to include a full study of the composition, utilization and contra-indications of drugs which the dentist may use in his future practice. Because it seems unlikely that this could be achieved in the dental curriculum, the Committee believes that it is important to develop a drug formulary specifically for dentists to supplement their own knowledge of the subject gained in the dental school, and to keep them up to date with the rapid developments in the introduction of new drugs and their utilization.

Recommendation:

- 46 That a drug formulary be developed for dentists listing the commonly used drugs with which dentists should be familiar, their side effects and other such information as would be required.

Graduate and Postgraduate Programs

For many years the University of Toronto Faculty of Dentistry was the only school in Canada providing graduate and postgraduate education and research facilities for dentists. Despite the development of some graduate programs in dentistry at other schools in Canada, Toronto remains the centre of this activity.⁶⁰ Its operation consequently has importance at a provincial, a national, and in some fields an international, level.

Although dental schools rely heavily upon practising dentists and also upon faculty from the basic sciences departments of their universities for most of their staff, they also require staff trained in graduate and postgraduate programs for their specialized dental faculty. Toronto is the principal Canadian source of such staff for dental schools across the country. It is also a centre for the research work which accompanies the education of professionals with these qualifications. The Division of Postgraduate Dental Education offers programs of study which may be classified as graduate, postgraduate and continuing education.

Graduate programs consist of courses of study offered to graduates of the D.D.S. course or its equivalent, designed specifically to prepare research workers, rather

⁶⁰The University of Western Ontario announced in the November 20, 1969 edition of *The University of Western Ontario News* that it plans to introduce in 1971-1972 a M. Clin. Dent. in oral surgery, orthodontics, paedodontics and periodontics.

than to raise the "professional qualifications" of those taking them. These courses lead to either a Master of Science in Dentistry or a Doctor of Philosophy degree.

Postgraduate education is offered through diploma courses, a program leading to the degree of Bachelor of Science in Dentistry, and occasional studies in which dental graduates may take courses in a field of interest without proceeding to a diploma or degree.

The diploma courses referred to are the source of specialists in the fields of dental public health, oral surgery and anaesthesia, orthodontics, paedodontics, and periodontics. These courses emphasize public health or clinical work, unlike the graduate courses referred to above, which emphasize the basic sciences and research work associated with them. (The Bachelor of Science in Dentistry program may be so organized as to permit a candidate to advance his knowledge in *either* "academic" or "clinical" fields of study.) The diploma course in dental public health requires one academic session and an additional period of field experience acceptable to the faculty; oral surgery and anaesthesia require a minimum period of thirty-two consecutive months, eight of which are spent in theoretical studies and the following twenty-four in a hospital internship; paedodontics, periodontics and orthodontics each require twenty-two months of study.

These programs to prepare dental specialists are expensive and time consuming. Most of them depend heavily upon the availability of scarce hospital clinical facilities, especially where oral surgery and periodontics are concerned. It is not surprising that the numbers of such specialties are few and their services costly. The Committee is satisfied that the present specialist training programs in dentistry are sound and extremely valuable, and that no unnecessary obstructions should be put in the way of their expansion to meet future needs, both here in Ontario and elsewhere. As noted earlier, recognition of dental specialties by licensing bodies in the various provincial jurisdictions has not been uniform, a condition which has probably discouraged specialization and impeded the geographical mobility of graduates of these programs.

Recommendation:

- 47 That dental specialty training programs continue to be given under the aegis of the faculties of dentistry.

The Committee recognizes the advantages which may develop through the establishment of the Royal College of Dentists of Canada, in that it will encourage the establishment of country-wide standards and recognition of specialists and will facilitate their mobility within Canada.

The Committee fears that dental faculties may experience difficulty in obtaining access to all the hospital facilities required for the preparation of dental specialists, particularly those working in oral surgery and periodontics. The Committee believes that hospitals should be specifically instructed to cooperate in the training of such dental specialists.

Recommendation:

- 48** That the Public Hospitals Act be amended to provide that certain hospitals be required to make the necessary facilities available and permit inpatients and outpatients to be available for the training of dental oral surgeons and periodontists in hospitals.

The continuing education programs available for dental graduates in the University of Toronto faculty have been designed to enable practising dentists to review their knowledge of particular fields in dentistry and to become acquainted with new methods and procedures in various areas of clinical practice. While relatively few dentists make use of these formal programs of continuing education, many do attend lectures and clinics sponsored by the dental school and by the Royal College of Dental Surgeons of Ontario, and those sometimes arranged by local dental societies throughout the province.⁶¹

The Committee is not satisfied that these existing arrangements for continuing education in dentistry go far enough towards ensuring that dental practitioners will keep abreast of improvements in dental knowledge throughout their professional lives. We have no reason to believe that the reason for the lack of interest in formal refresher courses and in improving the overall knowledge of the dentist lies in the programs and facilities which have been offered. But we have heard evidence which suggests to us that a strong inducement will be required to make dentists fulfil what the Committee regards as one of their responsibilities to their patients.

Competence could be maintained in a number of ways. We realize, as we have indicated in Chapter 8, that the development of procedures for ensuring continuing competence is not an easy matter. It is our belief that a number of procedures or types of programs might serve the purpose, with some more appropriate than others, depending upon the circumstances of the practitioner.

Recommendations:

- 49** That a program for ensuring continuing competence be implemented for dentists and that periodically, perhaps every five years, every dentist in Ontario be required to present to the Royal College of Dental Surgeons of Ontario a certificate from a dental school in Ontario stating that he has maintained a satisfactory level of competence in the areas of dentistry in which he ordinarily practises.
- 50** That the Ontario faculties of dentistry develop the standards and programs which would be required for such certification; these could include formal course work, a contribution to the profession through research or teaching, or other appropriate methods.

⁶¹Royal College of Dental Surgeons of Ontario, reply to Questionnaire "A", Committee on the Healing Arts, 1966, p. 11.

Dental Hygienist Programs

The formal education of dental hygienists in Canada dates from 1951, when the University of Toronto Faculty of Dentistry established a two-year course leading to the diploma in dental hygiene. Similar courses are now offered or are being organized at a number of other Canadian dental schools. At the University of Western Ontario,⁶² by 1971-1972 it is planned to introduce a four-year honours program in dental hygiene, but with an initial enrolment of only ten students per year. Facilities for preparing dental hygienists were extremely limited throughout the 1950's, when space was available for only about a dozen students each year in all of Canada.⁶³ Although Toronto alone can now accommodate fifty, many more qualified applicants are forthcoming than there are spaces for.

Given the extremely limited range of duties hygienists may perform, it is not apparent why their training need continue indefinitely to be taken under university auspices, or even why it should require two years. Because they are taught in university dental schools, hygienists take up space and staff otherwise available to prepare dentists. And because university entrance requirements must be met, the potential supply of hygienists is greatly restricted. To date this has not been a problem, but if we envision a great increase in the use of hygienists in the typical dental practice of the future, such restrictions built into the system could create a serious problem.

The admission requirements for hygienists are made even more restrictive by the imposition of an aptitude test and the exclusion of male applicants. Why hygienists should have to be female while dentists may be of either sex is a mystery that spokesmen for the dental profession have not explained to the satisfaction of this Committee.⁶⁴

Although these existing requirements are clearly the work of the organized dental profession, the Ontario Dental Hygienists Association appears to agree with the spirit of them. Displaying the familiar behaviour of members of an occupation aspiring to "professional" status, the representatives of the organized hygienists have taken the position before this Committee that the training of dental technicians should be further extended to the university degree level, with "majors" being offered in education, administration and public health.⁶⁵

Although the Committee is impressed by the contribution dental hygienists and other auxiliaries can make to dental practice, and although we have urged⁶⁶ an expansion of their role, the Committee is not convinced that even the existing educational requirements for dental hygienists can be justified, given the types of work which they are now authorized to do.

⁶²*The University of Western Ontario News*, Vol. 5, No. 16, November 20, 1969.

⁶³K. J. Paynter, *op. cit.*, p. 76.

⁶⁴The Royal College of Dental Surgeons, Transcript of the Hearings of the Committee on the Healing Arts, April 3, 1967, p. 1955.

⁶⁵Ontario Dental Hygienists Association, Brief to the Committee on the Healing Arts, 1967, item 2.

⁶⁶See pp. 119-120.

Recommendation:

- 51** That for the time being the training of dental hygienists continue in universities under appropriate faculties of dentistry but that the course should be shortened to one year after grade thirteen; and that the training programs for dental hygienists be reviewed continually by the Department of Health and the Ontario Council of Health and when feasible be moved from the universities to Colleges of Applied Arts and Technology, at which time an entrance requirement of grade twelve might be considered.

One of the consequences of requiring that hygienists be women is that many hygienists drop out of employment at some point to marry and to have children. As with other female workers, it may be possible to attract many of these women back into the occupation at some later time. We will allude to this again when the subject of dental manpower problems is considered later in this chapter. It will facilitate such re-employment, however, if educational programs exist for refreshing the skills of such workers.

Recommendation:

- 52** That appropriate programs be developed by schools teaching dental hygiene to provide refresher and retraining programs for hygienists who wish to return to practice.

Other Dental Education: Dental Technicians

Like other workers in dentistry, dental technicians require a combination of technical skills and manipulative dexterity. It appears that both can be acquired through apprenticeship or by having some years of formal training in a technical school or college followed by a period of practical employment experience. One advantage of the latter method is that it permits the use of instructors trained to teach their subject. Another is that it facilitates the incorporation of academic subjects in the training program, some of which may be very useful to the student who hopes to become licensed as a registered dental technician and eventually to establish his own dental laboratory business. It is also apparent, however, that many technicians, especially those emigrating to Canada from Europe, have learned to do their work well simply by on-the-job apprenticeship, even when they lacked sufficient academic background. It is apparent too that many dental technicians are not interested in becoming licensed as registered dental technicians or in establishing dental laboratories of their own.

Because of this, the Committee is persuaded both that the existing types of preparation for dental technicians should continue to be made available and that only minimal academic requirements should be imposed upon those who wish to pursue the apprenticeship route to obtaining their qualifications to work as dental technicians.

Recommendation:

- 53** That two avenues of gaining qualification as a dental technician should

be open: one via an entrance requirement of grade twelve and completion of an approved program at a College of Applied Arts and Technology, and another via the apprenticeship route as at present, but removing the requirement of grade twelve and requiring only grade ten with the additional requirement that the applicant have an adequate knowledge of the English language.

Manpower Considerations in Dentistry

Dentists and their auxiliaries are widely thought of as being in short supply. Yet spokesmen for the profession deny that a shortage of dentists exists. Although it is difficult to estimate the available supply of dental services accurately, the principal reason for this disagreement is found in the different approaches which may be taken to estimating the demand for these services.

The "need" for dental services is enormous; for as we have already seen, the entire population requires more preventive care than can now be provided and, even worse, the existing volume of repair work required to bring the population up to an adequate level of dental health could not conceivably be provided by the existing services. It was from this standpoint the Royal Commission on Health Services observed in 1964 that:

. . . the shortage of dentists in Canada is so acute . . . , however desirable and necessary it might be, it is impossible to think at the present time in terms of a programme of dental services for the entire population.⁶⁷

Those who believe that the existing supplies of dental services are reasonably adequate tend to look not at estimates of "need" but at the effective demand for dental services in the community. The Royal College of Dental Surgeons of Ontario emphasizes this distinction in the following representation made to this Committee:

There is no adequate information on the discrepancy between need for dental services and effective demand. Many patients who need dental treatment do not seek it for many reasons, of which economics plays a much smaller part than is generally supposed. When the need for dental treatment is weighed in the preference scale with liquor, tobacco, and television sets it is rated very low by a large percentage of the population. Then there are the procrastinators and the large segment of the population who, in spite of the best efforts of health educators, do not seek dental treatment until a painful emergency drives them to it.⁶⁸

The College supports its claim that the cost of dental service to the patient is not as great a deterrent as might otherwise be believed by noting that:

Under the Mothers' and Dependent Fathers' Allowance Act in Ontario a considerable number of children and adults are eligible for free dental treatment at the expense of the taxpayer. In spite of the free availability of this service the percentage of those eligible who sought dental treatment

⁶⁷*Report of the Royal Commission on Health Services, op. cit.*, p. 35.

⁶⁸Royal College of Dental Surgeons of Ontario, Brief to the Committee on the Healing Arts, 1966, pp. 7-8.

has consistently remained at about thirty per cent, or roughly one individual in three. The same is true in the armed forces where superior and well controlled dental treatment is provided without cost to the armed forces personnel. A relatively broad survey by the Royal Canadian Dental Corps has shown that only thirty-two point three per cent of those in the armed forces sought regular dental treatment. Relatively the same percentage utilization has been found to exist in Alberta where publicly financed dental treatment has been made available.⁶⁹

Fortunately, everyone appears to agree that from a public health standpoint, the demand for dental services should be greater than it now is, especially in the case of preventive services for children. The Committee shares this belief and is convinced that public policy should be directed to encouraging parents to seek dental care for their children, not only to save the unnecessary suffering that neglect of children's teeth causes, but also because it is likely to prove more economical for society to prevent dental disease than to cure it. To this end, existing dental public health measures should be continued and expanded, especially those that serve to educate the public in dental health matters. But the Committee believes that a more direct effort also is needed if large gains are to be made in this endeavour.

Recommendation:

- 54** That the Department of Health in conjunction with the Department of Education ensure that every primary school child in Ontario has a dental inspection at least once a year and that provision be made through the public health units for such inspections where they have not been done privately. A report of the inspection together with information regarding facilities where the child may receive appropriate dental treatment should be mailed to the parents of the child. The public health units should ensure that facilities are available for such treatment through either private dentists or public health dental units as appropriate.

In addition to these deliberate measures to increase the amount of dental care demanded in the community, a number of other factors may be expected to work to the same effect. The demand for dental care will increase as a result of population growth, rising levels of personal income, higher levels of education, and, perhaps, the urbanization of the population. The Committee believes that the provision of new means of financing dental care in the future will serve to increase the quantity of these services demanded by the population. There is already a strong movement towards the inclusion of dental care in the coverage offered to the public by private health insurance plans in this province, and the Committee thinks it reasonable to believe that this will lead to a more rapid rate of increase in the demand for dental services. To some extent it may be expected that these forces will be offset by the effect of more preventive work, by fluoridation of water supplies, and by better nutrition and dietary habits; but it appears unlikely that the latter will outweigh the former in the foreseeable future.

⁶⁹*Ibid.*

Although we are unable to quantify the extent of the foreseeable increase in demand for dental services in the future, the Committee is convinced that demand will increase and that it will increase faster than the rate of growth in our population. It will, therefore, be necessary to increase the supply of dental services to avoid manpower problems in this area in the future. This will entail increasing both the productivity of dentists and their numbers.

Several forces are already at work to increase the output of dental services and the Committee believes that these should be promoted, where possible, by appropriate policy measures.

We have already noted that the use of auxiliaries has increased the productivity of some dentists in recent years, and so too has the improvement of equipment and the organization of some dental practices. We have also seen how larger practices make more efficient use of ancillary personnel. The Committee believes that for this reason larger units of dental practice should be encouraged and that one means of doing this would be to relax the existing regulations which prevent the establishment of corporate practices. This appears to be warranted so long as appropriate guarantees can be maintained to ensure that professional integrity will be preserved in such practices.

Recommendation:

- 55** That dentists be permitted to form corporations for the practice of dentistry in Ontario, but that ownership of the shares of such corporations be restricted to dentists licensed to practise in the province of Ontario.

Group dental practices of various kinds have in the past enabled some dentists to obtain the advantages of larger units and the Committee believes that this, too, should be encouraged in the future.

Another possible factor affecting the productivity of dentists, both in general and in specialty practice, is their deployment within the province. Despite the attention given in public discussions to the geographical distribution of dentists and the problems of some communities lacking access to dental services, the Committee has been unable to discern any means for greatly increasing the total output of dental care simply by redistributing dentists geographically. Although dentists, and certainly dental specialists, are relatively scarce in many rural parts of the province, our inquiries suggest that this is attributable to relatively low demand (correlated with low family incomes) in rural as opposed to urban areas. Policies designed to induce dentists to locate in areas lacking access to dental care are definitely warranted by considerations of equity and the "rights" citizens may claim with regard to health care. And if some urban areas are oversupplied with dentists to the extent that dentists' services are underutilized, this is also undesirable. But we are unable to conclude that the total supply of dental services provided in the province as a whole could be much, if at all, increased through

a policy of encouraging relocation of dentists.⁷⁰ House's study shows that 37 per cent of dentists were too busy to treat all persons requesting appointments, and an additional 23 per cent of dentists had more work than they wanted. Only 7 per cent stated they would like more work.⁷¹

The principal factor determining the supply of dental services available in the province remains the number of qualified dentists available. This number is itself determined by the output of our dental schools and by the migration of dentists into and out of the province. The output of dental schools is in turn determined by their capacity and by their ability to attract enough qualified applicants to fill, and to keep filled, the spaces available.

With the opening of a second dental school in Ontario in 1965 our training capacity has been increased to the point where by 1974 we may expect to graduate 175 dentists, fifty dental hygienists, and thirty dental specialists annually. Even using conservative estimates of future demand for dental services, however, it does not appear to the Committee that this training capacity will prove adequate, especially in the case of the dental specialists and hygienists who will be required, unless there is some unexpected large increase in the productivity of dentists. Because the latter seems unlikely, the crude dentist:population ratios calculated in Chapter 6, Table 6 may have some significance as indicators of the adequacy of dental services in the population. Given the rough impressions of the likely future trend of demand for such services set out above, the Committee is persuaded that additional training facilities should be provided. So as to improve the geographical distribution of dentists to the extent that this is influenced by the location of training facilities, the Committee believes that this new capacity should be provided by establishing a new dental school, rather than by expanding the existing ones. In addition, we recommend later in this chapter that dental schools assume the responsibility for providing continuing education for dentists. While this will require substantial expansion on the part of the dental schools, we believe it to be most important. An additional dental school would, however, contribute to this proposed program by increasing the total dental school capacity and by adding a new geographical centre of education.

Recommendation:

- 56** That an additional faculty of dentistry be established in the province of Ontario in a university which presently has a faculty of medicine.*

In view of the excess of qualified applicants over the spaces available in dental schools in Ontario, it is not likely that a major problem of recruitment will be experienced in the foreseeable future. The work of the Ontario Dental Association

⁷⁰R. K. House, *op. cit.*, Ch. 3.

⁷¹*Ibid.*, Table 4, p. 22.

*See minority opinion, pp. 520-521.

and other professional bodies in publicizing the attractions of dental careers should continue, as should the type of financial assistance being made through public and private bursary schemes.

More should be done, however, to alleviate the financial obstacles to specialization in dentistry. The cost of most specialty training programs is extremely heavy and often comes at a time when the student's resources have been drained by the years spent in undergraduate study.

Recommendation:

- 57** That the university schools of dentistry ensure that adequate financing is available for students wishing to undertake specialty training in dentistry, either through arrangements for them to work part time, through payment in the same way as for medical internes, or through establishment of appropriate fellowship programs; and that the Province of Ontario assist in making such monies available to the universities.

Apart from the capacity of our own educational facilities, the other factor which affects the numbers of dentists and dental auxiliaries in the province is migration. Some Ontario dentists, including new graduates of Ontario dental schools, leave the province to practise elsewhere. In return, some dentists from other jurisdictions may come here. The Committee is convinced that such movements are beneficial, whatever their net effect on provincial dental manpower may be, and that impediments should not be placed in the way of such transfers of professional workers. Many such impediments exist at present, mainly as a consequence of restrictive regulations concerning educational and licensing requirements imposed in different jurisdictions. Although these restrictions in any one jurisdiction are normally designed to control only the immigration of dentists to that jurisdiction, this affects the freedom of dentists to move out of other jurisdictions. The overall effect is to reduce the mobility of these professional workers. Because restrictions on immigration are usually based upon some claim by those imposing them that relates to the problem of consumer protection, we will consider them in this context in the next section.

Regulation

The purpose of regulating the practice of dentistry is the same as for the practice of medicine, the protection of the public in a field where the consumer is apt to suffer harm or financial loss because of his inability to judge the need for or the quality of the service being rendered. By restricting the right of practice to those who possess what are judged to be the minimum necessary capabilities and by providing a procedure for disciplining members of this group to ensure their adherence to standards of ethical conduct, the public authority may hope to minimize the exposure of consumers to the risk of receiving incompetent or unethical treatment from their dentist. Because the government traditionally has doubted its competence to determine what these standards of competence and

conduct should be in certain occupations, it has delegated this task to professional organizations. We saw earlier in this chapter how this was effected in the case of dentistry by the legislation of 1868.⁷²

It will be convenient to discuss this regulatory system for dentistry in two parts: first, the provisions affecting entry to the profession and practice of dentistry in Ontario; second, the procedures for regulating dentists after they have been allowed to practise. The regulation of auxiliary workers in dentistry will be considered separately.

Licensing

Admission to the practice of dentistry in Ontario is controlled by a licensing power delegated to the Royal College of Dental Surgeons of Ontario by the provincial Legislature. The Dentistry Act authorizes the Board of the College to conduct examinations and provides that "if the Board is satisfied by the examination that the candidate is duly qualified to practise the profession of dental surgery and that he is a person of integrity and good moral character, it shall, subject to the by-laws, grant him a certificate of licence and the title of 'Licentiate of Dental Surgery'"⁷³ The Board is authorized to "dispense with such examination in the case of a person who proves to the satisfaction of the Board that he has passed in any university or college or at a national dental examining board an examination that the Board deems of equal value".⁷⁴ This the Board has done by accepting the Doctor of Dental Surgery degree (D.D.S.) from Ontario universities as evidence of qualification for the Licentiate. Consequently, graduates from these schools may expect automatically to qualify for admission to practice in Ontario. If they contemplate practising elsewhere in Canada, however, they must write separately the examinations of the National Dental Examining Board, success in which is recognized by most provincial dental licensing Boards.

In view of the relatively minor differences in standards for dentistry throughout Canada, the need for students to write this second set of examinations is not evident. The Committee believes that it is important to establish formally national standards for dentistry in order to attain greater mobility on the part of dentists in Canada.

Recommendation:

- 58** That the Ontario schools of dentistry work towards the establishment of joint examinations with the National Dental Examining Board to eliminate the necessity of two sets of examinations for the dental graduate.

Dentists who have obtained their training outside Canada are not admitted to practice in Ontario as simply as are graduates of Canadian dental schools.

⁷²See p. 111.

⁷³R.S.O. 1960, c. 91, s. 18(1).

⁷⁴R.S.O. 1960, c. 91, s. 17(5).

A complex and not altogether clear procedure for determining their qualifications has been evolved. Until recently this has been of little concern, for few dentists trained outside Canada sought a licence here. This may have been due in part to the restrictiveness of our licensing procedures, although this is difficult to assess empirically. McFarlane reported in 1964 that:

Between 1946 and 1960 immigration played a very important role in the supply of practitioners in most of the recognized professions in Canada *except* dentistry. Comparatively few dentists ever migrate to Canada.⁷⁵

Recently more dentists from abroad appear to have been interested in migrating to Canada. Although the policy of the Royal College of Dental Surgeons of Ontario has been altered, and may be changing further as this report is written, many dentists seeking a licence to practise here have faced formidable obstacles. In the past they were required to be Canadian citizens or to convince the Board of their intention to become such; to have had pre-dental educational qualifications "equivalent to those required of Ontario students"; and to present evidence of having had two years of approved pre-dental education and a four-year dental course. If their dental course had been at a dental school in the United States, the United Kingdom, Eire, Australia, New Zealand or South Africa, they were eligible to sit for Board examinations. The latter, which were mainly "clinical", were available to the student only if he could pay a \$100 examination fee, and furnish his own patients, instruments and materials. Graduates from dental schools in countries other than those mentioned were not eligible to sit for the Board's examinations until they had successfully completed two or more years of dental education at a faculty of dentistry in Ontario.⁷⁶ This, too, presented difficulties, however. In its submission to the Committee in 1966, the College reported:

Recently the number of graduates of European universities seeking admission with advanced standing to the Faculty has been eight to ten times the number of places which could be made available in the regular undergraduate classes. The limited facilities of this Faculty have necessitated a restriction on the number of candidates (both regular Canadian and all others) being admitted in any one year.⁷⁷

Consequently, a qualifying examination was implemented to screen candidates who, when selected, were admitted to the second dental year. Outstanding performance during this year could lead to direct promotion into the fourth year.

Recently these requirements have been relaxed, and at the time of writing it appears that the Board is preparing to permit graduates from *any* university dental school to attempt Board examinations. These examinations are being broadened to incorporate more basic science along with the clinical and practical skills tested. Relaxation of the citizenship requirements also is anticipated.

⁷⁵B. A. McFarlane, *op. cit.*, p. 186.

⁷⁶Royal College of Dental Surgeons of Ontario, Brief to the Committee on the Healing Arts, 1966, Appendix A(2).

⁷⁷*Ibid.*, Appendix A(3).

These changes are overdue. It is appreciated that the task of evaluating the quality of dental schools and the skills of their graduates is difficult, and that it may require resources not available to individual provincial licensing bodies. Because of this, and because it would be desirable to establish uniform licensing requirements and policies throughout Canada, such work could be more effectively done at the national level.

Recommendation:

- 59 That the Royal College of Dental Surgeons of Ontario should establish in conjunction with other licensing bodies and the federal Department of Manpower and Immigration, a Canada-wide system to provide objective evaluation of foreign dental schools; but if it is not possible for such a joint program to be developed at the federal level, Ontario should do so on its own.

With regard to licensing standards more generally, it does not appear reasonable to have ten different provincial sets of policies, a situation which confers no discernible benefits upon the Canadian public, but which impedes the free movement of dentists and dental auxiliary workers from one jurisdiction to another.

Recommendation:

- 60 That the Royal College of Dental Surgeons of Ontario take the initiative to establish a Federation of Licensing Bodies for Dentistry in Canada which could develop national standards for licensing of dentists and provide more flexible interchange of dental personnel between provinces.

Discipline

Once dentists have been admitted to practice, their professional conduct becomes the responsibility of the Board of the Royal College of Dental Surgeons of Ontario. This Board has also been left with the responsibility of enforcing the prohibitions contained in section 23 of the Dentistry Act against the illegal practice of dentistry by an unlicensed person. Discharge of the latter responsibility could be onerous if the College undertook to seek out instances of illegal practice; but in fact it confines itself to investigating only specific complaints. Even this entails some expense, and the Committee is of the opinion that more effective enforcement and a fairer allocation of the financial costs involved in carrying it out would be achieved by having it done at public expense, rather than at the expense of the members of the College as it is at present.

Recommendation:

- 61 That the Royal College of Dental Surgeons of Ontario no longer be required to prosecute persons for unauthorized practice under the Dentistry Act, but that this responsibility be transferred to the Crown Attorney for the county in which the offence is alleged to have been committed.

Each year from five to ten cases of such illegal practice are taken to court. The kind of work involved is usually the taking of impressions and the production of dentures rather than the preparing and filling of cavities or extractions.⁷⁸

The disciplining of members of the profession themselves is also largely a matter of the Discipline Committee of the Board investigating and acting upon complaints received by patients against dentists who have done work for them. These complaints could concern the professional competence of the dentist, but this is seldom the case. The Board of the College is empowered to require any dentists who, in the Board's opinion, are performing substandard work to demonstrate their competence, to take remedial courses, or to surrender their licences to practise. But patients are unlikely to be able to discern or to demonstrate professional incompetence of this kind, and it is not likely that many complaints and investigations on this point would be recorded even if such incompetence were prevalent. No system exists through which the Board inspects the work being done by dentists once they have entered practice.

More common, but still few in number, are complaints concerning unhygienic premises, infractions of the Council's by-laws relating to advertising (sometimes initiated by colleagues), and complaints concerning fees. Occasionally cases have also arisen in which members of the profession have been charged with assault, or with alcohol or drug abuses, and these have been dealt with under the powers of the Board to discipline members guilty of "infamous, disgraceful or improper conduct".⁷⁹

Some patients' complaints are dealt with at a local level without reaching the Complaints or Discipline Committee of the Board. Most local dental societies have their own non-statutory mediation committee to deal with such grievances. In mediating cases involving disputes over fees, the Board recommends the Ontario Dental Association's published fee schedule as a reference. The Board has no authority to regulate fees charged by individual dentists, however, and there have been no discipline cases concerning exorbitant charges.⁸⁰ This does not mean that patients are always satisfied by such "mediations". Often the dispute reflects the dentist's failure to make clear to the patient the extent of the work needed.⁸¹ The opportunity for such misunderstanding is particularly prevalent where dentures or other prosthetic devices are prescribed by the dentist. The manufacture of such devices is now usually done in a commercial laboratory to the dentist's order, and the laboratory is strictly prohibited by the Dentistry Act from having any dealings with the patient. Because the patient is forced to purchase these appliances through his dentist, it is not surprising that some should

⁷⁸*A Comparative Study of Discipline in the Healing Arts in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

⁷⁹R.S.O. 1960, c. 91, s. 25(18).

⁸⁰*A Comparative Study of Disciplines in the Healing Arts in Ontario*, *op. cit.*

⁸¹*Ibid.*

suspect the dentist of taking financial advantage of the monopoly situation. To minimize this concern, the Committee believes it would be useful to have dentists' services and the costs of prosthetic appliances more clearly distinguished.

Recommendation:

- 62** That it be mandatory that a dentist submit to his patient an itemized bill showing charges for professional fees and charges for dental appliances supplied; that the Royal College of Dental Surgeons of Ontario should declare as unprofessional conduct any mark-up by a dentist on a dental appliance dispensed; and that a dentist be allowed to charge only for professional services involved in the prescribing, fitting or adjusting of such dental appliances.

Another source of difficulty over fees is the variation in what different dentists may charge for what appears to the patient to be the same work. The preamble to the Ontario Dental Association schedule of fees notes that it "represents fair charges to persons of average means for dental services requiring average ability, skill and responsibility"; but it notes also that it is considered reasonable for a dentist to reserve the right to increase his fees in "unusual circumstances" or in "complicated cases requiring more time, greater than average skill and responsibility", or to reduce fees in cases where "a regular fee might be a financial hardship to the patient".⁸²

"Fair" as such an approach to fee setting may be, like the rest of the system for regulating the practice of dentistry, it is based upon judgment unilaterally exercised by members of the profession itself. Although the reasons, historical and logical, for this are fully acknowledged, this Committee is not satisfied that the protection of the public interest is sufficiently visible in these arrangements.

Recommendation:

- 63** That the fee schedule published by the Ontario Dental Association be a matter of prior negotiation by the Association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.

The Committee recognizes the problems involved in rewarding excellence but would hope that the Fee Negotiations Advisory Committee⁸³ would be able to develop means by which such excellence may be taken into consideration.

The Committee also believes that more direct participation by non-dentists in the work of the Council of the Royal College of Dental Surgeons of Ontario, especially on its committees having to do with regulation of the practice, would contribute to public understanding of its policies.

⁸²Ontario Dental Association, *Schedule of Fees*, p. 5.

⁸³See Chapter 24 for full description.

Recommendation:

- 64** That there be representation from the Department of Health and significant lay representation on the Council of the Royal College of Dental Surgeons of Ontario, and that there should also be lay representation on the Discipline Committee of the College.

This is parallel with our recommendations concerning other professional bodies set out elsewhere in this Report.

Dentists and Physicians

As we noted at the beginning of this chapter, dentistry has long been a practice and a profession separate from that of general medicine and surgery in most western countries. The distinction between dentists and physicians appears to be quite clear to the public at large, despite the existence of areas where dentistry and the practice of medicine overlap. And despite the specific "jurisdictional dispute" between oral and plastic surgeons alluded to above, the medical and dental practitioners have worked out what this Committee takes to be reasonable and well-understood boundaries between dentistry and medicine. If there is fault in these arrangements, it is the Committee's opinion that dentistry has been too confined rather than the contrary. The Committee sees no reason, therefore, to recommend further limitations on the practice of dentistry or to interfere with the dentist's long-established and apparently valued right to use the designation of "Doctor".

Recommendation:

- 65** That the present exception of dentists from the Medical Act continue and that dentists should continue as in the past to be able to use the title "Doctor".

Regulation of Other Dental Personnel

A striking feature of the arrangements concerning dental hygienists and dental technicians is the extent to which they are subject to the authority of the Royal College of Dental Surgeons of Ontario.

In the case of the dental hygienists, this hegemony of the College is established explicitly by the Dentistry Act, which authorizes the Board of the College to pass by-laws "providing for the establishment, development, regulation and control of an ancillary body known as dental hygienists; . . . regulating the conditions and prescribing the qualifications for admission and annual fees payable by members of such body; (and) generally for the defining, regulation and controlling of the practice of dental hygiene".⁸⁴

All dental hygienists wishing to practise in Ontario must obtain a licence issued by the Board of the Royal College of Dental Surgeons of Ontario. This

⁸⁴R.S.O. 1960, c. 91, s. 12.

is issued without further examination to graduates of an Ontario faculty of dentistry. Graduates of schools outside the province are required to pass both a practical and a comprehensive oral examination set by the Board. Only female persons are eligible for licensing and it is required that applicants be Canadian citizens or intend to apply for Canadian citizenship.⁸⁵

Once licensed, dental hygienists are subject to the disciplinary powers of the College according to its by-law number 15. To our knowledge, no disciplinary action has ever been taken under these provisions, and although the Ontario Dental Hygienists Association has requested that a dental hygienist be a member of the discipline committee whenever a case does arise, there appears to be little concern over discipline in this area.⁸⁶ As noted earlier, dental hygienists work under the direct supervision of dentists, performing tasks which are clearly specified in legislation and regulations. While there is considerable interest on the part of dental hygienists themselves in having the scope of their permitted activities expanded, they appear to have no difficulty practising within the limits now established.⁸⁷

The Committee has set out elsewhere⁸⁸ its reasons for objecting to arrangements whereby one occupational group is given the power to regulate the activities of another group. In the case of the dental hygienists it seems particularly inappropriate that the work of this group should be limited and regulated by a body representing the private practitioners who are their employers, a situation which could be suspected of leading to socially unwarranted restrictions being placed on the subordinate practice.

Recommendation:

66 That the licensing of dental hygienists should cease to be a responsibility of the Royal College of Dental Surgeons of Ontario, and instead be made the responsibility of the proposed Health Disciplines Regulation Board through a Dental Hygienists Division, and that in the legislation outlining the requirements for licensing by the Board there be no restrictions regarding sex, age, nationality or citizenship.

Dental technicians in Ontario are regulated under the provisions of the Dental Technicians Act.⁸⁹ As noted earlier there are two classes of persons employed as dental technicians, one of which is licensed to practise under the Ontario Dental Technicians Act, and the other not. Only licensed dental technicians are permitted, under Ontario legislation, to own and to operate dental laboratories.⁹⁰

⁸⁵Royal College of Dental Surgeons of Ontario, reply to Questionnaire "A", Committee on the Healing Arts.

⁸⁶Ontario Dental Hygienists Association, Brief to the Committee on the Healing Arts, 1967, item 3.

⁸⁷Ontario Dental Hygienists Association, Transcript of the Hearings of the Committee on the Healing Arts, June 14, 1967, pp. 4537-4560.

⁸⁸Chapter 25.

⁸⁹R.S.O. 1960, c. 90.

⁹⁰*Ibid.*

Only such licensed technicians are entitled to call themselves "Registered Dental Technicians".⁹¹ Most of the employees working in dental laboratories are not licensed (i.e. not registered dental technicians).

The examining, certifying and disciplining of registered dental technicians is entrusted by the Dental Technicians Act to a body known as the Governing Board of Dental Technicians of the Province of Ontario, a board comprising five members appointed by the Lieutenant Governor in Council and empowered to make regulations prescribing qualifications for admission to the business, maintaining a register, and prescribing standards of competence and ethics in their work. The interest of the dental profession in this activity is represented by a dentist customarily appointed to the Board and by a provision in the Act requiring that all regulations made by the Board be submitted to the Royal College of Dental Surgeons of Ontario before being presented for approval to the Lieutenant Governor in Council. If the College wishes to make submissions concerning the proposed regulations, these representations accompany them when they are submitted.⁹²

These arrangements concerning regulation of dental technicians must be understood in terms of the concern of dentists and legislators about the delegation of the work of manufacturing dentures to non-dentists. The dental profession has resorted to this delegation of technical work for reasons explained elsewhere, but it remains convinced that none of the work done in the patient's mouth can be delegated to technicians. Thus, technicians are strictly prohibited from dealing with patients and most of the legislation and regulations concerning them are related to this objective. How severe these restrictions need be is a contentious point. In some jurisdictions, notably British Columbia in this country, laboratories are permitted to serve the public directly. But here, as in most other jurisdictions, the prohibition on "denturism" is complete. It is an offence for a dental laboratory in this province even to effect a minor repair to a denture unless it is prescribed by a dentist. The system of regulation which has grown up to ensure the maintenance of this limitation on the work of the dental technician has, perhaps inadvertently, come to combine measures to regulate an industry — the manufacture of dental prostheses — with measures to regulate a group of health workers, some of whom are owner-operators and others their employees.

The Committee is persuaded that the dental profession's monopoly on the prescribing and fitting of dental prosthetics does serve the public interest by ensuring the safety of the patient from some health risks which could arise if this work were done by persons lacking the dentist's training in the basic health sciences relevant to an understanding of the mouth. We are also of the opinion that because the dental laboratory industry is involved with the health of

⁹¹For clarification of the terms "licensed" and "certified", see Chapter 25.

⁹²The Governing Board of Dental Technicians of the Province of Ontario, reply to Questionnaire "A", Committee on the Healing Arts.

the public, it should be subject to some form of regulation. Consequently the Committee is agreed that all dental laboratories should be required to obtain a licence and to meet such standards as are required to protect the public interest in this area. While the Department of Health would develop the initial requirements for licensing, the Health Facilities Board (described more fully in Chapter 24) should administer the licensing plan and carry out the ongoing inspection of laboratories for the Department. The Health Facilities Board should also have the authority to suspend or revoke the licences of laboratories in order to ensure compliance with the regulations establishing standards. We believe that such regulations should be kept to a minimum, however, and that more price competition among laboratories should be encouraged. Existing restrictions on advertising by dental laboratories are probably excessive, although we believe that it would not be desirable to allow laboratories to advertise directly to the public.

Recommendations:

- 67 That the Department of Health enact legislation to license dental laboratories in the province of Ontario. Such legislation should include a requirement that all such laboratories be licensed and that they be prohibited from dealing directly with the public. The Health Facilities Board should administer the licensing scheme. No requirements regarding qualifications of owners should be included and corporate ownership of such laboratories should not be prohibited. Regulations regarding quality control, advertising and other matters affecting laboratories should be established, but such requirements should be kept to the minimum required consistent with the public interest. The Health Facilities Board should have the power to suspend a licence, but the conditions under which such suspension might take place should be included in the legislation.
- 68 That dentists should be required to provide a formal prescription to dental laboratories for each item ordered; and that, if dentists ignore this requirement, this should be a matter for disciplinary action by the Royal College of Dental Surgeons.

Under these arrangements to regulate dental laboratories, it would not be necessary to maintain the present elaborate regulations affecting dental technicians themselves, a group which the Committee believes has been overregulated. Certainly it would be unnecessary to require that only registered dental technicians, as presently defined, could own or operate dental laboratories. Some regulation of dental technicians will be required, however, and the Committee proposes that this be effected through certification of those who possess a level of skill to be established by the Health Disciplines Regulation Board,⁹³ whether this be attained

⁹³See Chapter 25 for full description.

through an apprenticeship or a formal training program.⁹⁴ The Committee does not believe that it would be necessary to require certification as a condition of employment in a dental laboratory.

Recommendation:

- 69** That dental technicians be certified by the Health Disciplines Regulation Board through a Dental Technicians' Division. The Board should make provision for certifying dental technicians trained outside Ontario, but who have the equivalent education and/or experience, on the basis of their competence. Certification would not be a requirement for the practice of dental technology but only those so certified should be able to use the title "Registered Dental Technician".

Conclusion

The practice of dentistry in Ontario today epitomizes the independent, fee-for-service approach to the provision of professional services. The education and regulation of dental practitioners, and also their auxiliaries, have been subject to relatively little external control or influence, except for some notable limitations imposed by the medical profession on the scope of dental practice.

Under this system of professional autonomy, most Ontario residents have had access to high quality dental services. The profession has imposed high standards for admission to the practice and, as a consequence, the cost of dental care to the consumer has been high. Yet this system of providing dental services has been surprisingly inflexible. It has not responded easily to changing public attitudes and needs, to new methods of organizing the provision of health services, or to new ways of preparing dental personnel to provide these services. The profession's preoccupation with maintaining "quality of service" appears to have been the chief obstacle to innovation in dentistry. Individual private practice, high entry requirements, fee for service, emphasis on repair rather than prevention, distrust of independent auxiliaries, all can be understood in the light of this concern with maintaining a self-imposed standard of quality in dental service, the exact nature of which only dentists themselves apparently are thought competent to understand.

The Committee has attempted to make recommendations in this chapter which will open up dentistry to more outside influence, including influence from the consuming public, without disrupting the traditional framework of professional organization. This opening up of the profession is needed to ensure its adaptability to the new patterns of health care which we see emerging in the future. The preservation of the traditional framework of the profession is needed to retain the sense of professional integrity and responsibility which has been one of the admirable characteristics of the profession in the past.

⁹⁴See Recommendation 53.

With regard to education, we have urged that the capacity of the training facilities for dentists be increased by the creation of a third university dental faculty; that more emphasis be put on the use of auxiliaries, and on preventive dentistry in the undergraduate curriculum; that means of financially assisting the training of specialists be augmented; that new arrangements be made for the accrediting of dental schools; and that a program of ensuring continuing competence be implemented. More generally, we have recommended various measures to strengthen the role of specialists, to encourage more dentists to become associated with hospitals, and to clarify the role of the voluntary association. We have stressed the need for the establishment of national standards for dental education and practice, and for the licensing of dentists. Several measures have been proposed to provide for more public and consumer participation in the regulation of dental practice, particularly where discipline and fee-setting are concerned.

With regard to the quantity of dental services required in the province, the Committee has recommended establishment of an extensive school dental health program, which we expect will require a sharp increase in both private and public dental services. In addition to the new dental school output, the Committee is looking to an increase in the productivity of dentists as a means of meeting the expected increase in the demand for dental services arising from the school program and from other causes. Our recommendations concerning dental hygienists, dental technicians, and new kinds of dental workers have been framed with this hoped-for increase in the productivity of fully trained dentists in view.

Chapter 10 Nursing

The nursing profession, while perhaps not as old a discipline in its present form as the medical profession, has nevertheless for a substantial period played a very important part in health care. In numbers, it is by far the largest group to have contact with patients and it provides the greatest quantity of care.

Nursing has been extensively discussed in recent years. However, as with most disciplines, the Committee commissioned a special study of nursing in Ontario, undertaken by Professor V. V. Murray of the Faculty of Administrative Studies and Department of Sociology of York University. Much of the material in this chapter is based upon Murray's study, which is published as a separate volume.

The Practice of Nursing

History and Organization of Professional Nursing in Ontario

Much of the modern practice of nursing in North America has evolved directly from the system devised by Florence Nightingale in England about the middle of the nineteenth century. The Nightingale approach itself combined elements of earlier nursing methods practised by religious nursing orders with additional organizational principles borrowed from the model of the British army. Under the influence of the Nightingale system, nursing preparation and practice came to emphasize the deliberate indoctrination of students, strict discipline, and hierarchical control within the occupation. As one writer has described the system, students and graduate nurses "were expected to give their total attention to nursing and they worked long hours. The student learned by apprenticeship to the ward sister and functioned as a staff nurse. Each rank exercised rigorous (and not always kindly) discipline over the lower rank, and supervision of personal as well as occupational life was minute".¹

This approach to nursing migrated to North America in the 1870's. The first "Nightingale school" was established in the United States in 1873. A year later the first Canadian training school for nurses was opened at St. Catharines. Both schools differed from the original Nightingale model in that they were set up under the direct control of the hospitals with which they were associated. This feature was to typify most of the nursing schools subsequently established in North America.²

¹W. A. Glaser, "Nursing Leadership and Policy: Some Cross-National Comparisons" in F. Davis (ed.), *The Nursing Profession: Five Sociological Essays*, John Wiley and Sons, New York, 1965, p. 6.

²H. K. Mussallem, *Nursing Education in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1965, p. 6.

Although the modified Nightingale approach used in these hospital schools of nursing thus came to dominate nursing education and practice in Canada, it was not unopposed. The principal opposition came from a group of nursing leaders in England and North America who dreamed of making nursing into a profession for women on a par with the new male professions, such as accountancy, and ultimately even with law and medicine.

Advocates of the professionalization of nursing declared from the outset their opposition to the hospital schools of nursing, the "diploma mills", which they believed to be concerned less with educating nurses than with supplying tractable, inexpensive labour to hospitals. The struggle between those who saw in nursing a professional career for highly educated women, and those who saw it mainly as a vocation in which suitably trained and motivated young women could render service to the sick, continues unabated to this day. The main strength of the professional movement has been located in the university schools of nursing. These originated in the United States where some colleges and universities proved willing at an early stage to offer courses in nursing, notwithstanding the absence of any "scientific" foundation for such a discipline.³ The first basic nursing program offered at the university level in the United States was provided by the University of Minnesota in 1909. The degree of Bachelor of Nursing was first given by the same university in 1916.⁴ Once established in the universities and colleges, the "nurse educators" in the United States began producing literature on nursing as a professional discipline. This, along with other contacts, was used to support the development of a professional nursing movement in Canada.

Although the hospital schools of nursing still survive in both countries, the trend at present is clearly in the direction of transferring the preparation of nurses into educational settings — independent schools of nursing, colleges and universities. How far this has now gone in the United States may be inferred from a recent position paper published by the American Nurses Association (ANA) on the subject. It flatly asserts that all preparation for nursing should take place in "institutions of higher learning"; that the minimum preparation for beginning "professional" nursing practice should be baccalaureate-degree education in nursing; and that "associate degree" level preparation should be the prerequisite for beginning "technical" nursing practice.⁵ To date, however, this goal is far from being achieved in the United States, for while there has been a rapid growth in associate degree "programs", the majority of nurses are still prepared in hospital schools of nursing. Although the teaching of nursing as a professional discipline has gained acceptance more slowly in the universities of the United Kingdom and Canada,

³H. Wilensky, "The Professionalization of Everyone?", *American Journal of Sociology*, Vol. 70, No. 2, September 1964.

⁴H. K. Mussallem, *op. cit.*, p. 75.

⁵See Anne Kilbrick, "Why Collegiate Programs for Nurses", *New England Journal of Medicine*, Vol. 278, No. 14, April 4, 1968, pp.765-771. At present the bulk of nursing education in the United States still takes place in hospital schools. Associate degrees are given to graduates of nursing programs from junior colleges.

such courses are now well established in these countries as well as in the United States. The first Canadian degree program in nursing in Canada was offered by the University of British Columbia in 1919, only three years after the first degree in nursing was given in the United States.⁶ At present, eight universities in Ontario offer baccalaureate degrees in nursing.

In addition to the ideal of university preparation, the professional nursing movement also called for the establishment of a professional organization with powers to regulate the practice of nursing and nursing practitioners. This necessarily involved an appeal to the state, in which are vested such powers, and under the Canadian constitution this has meant an appeal to the provincial authority. Thus, in each province we find a professional organization of nurses, all but one of which has been assigned responsibility for administering the nursing practice Acts of the province concerned. These Acts provide for the registration of nurses, for setting admission requirements for schools of nursing, and sometimes for approving or "inspecting" these schools. In all provinces except Ontario the fee for "registration" as a nurse includes membership in the provincial nurses' association.

The ten provincial associations are organized into a national federation, the Canadian Nurses' Association.

The organization of the nursing profession in Ontario began with the formation of the Graduate Nurses' Association of Ontario in 1904. In 1922 this body succeeded in having the Nurses Act⁷ passed, an Act which made a government department responsible for registering qualified nurses. The Graduate Nurses' Association was subsequently renamed the Registered Nurses' Association of Ontario (RNAO).

In 1951 the nursing profession in Ontario was given extensive legal powers of self-regulation. The Nurses Registration Act⁸ of that year granted the RNAO control over registration of nurses, the approval and inspection of schools of nursing, educational programs in these schools, and the discipline of registered nurses.

During the late 1950's the RNAO sought to extend its power over practitioners of nursing by asking the government to make membership in the RNAO compulsory for registered nurses. It also reiterated its demands for the licensing of "all who nurse for hire", the latter having been one of the original objectives of the organization set up in 1904. These requests were not granted, but in 1961 the Nurses Act was amended to provide for the establishment of a College of Nurses to take over the registration and regulation of nurses.⁹

The College of Nurses of Ontario established in 1963 is responsible for establishing minimum educational standards for schools of nursing, the conduct of regis-

⁶H. K. Mussallem, *op. cit.*, p. 75.

⁷S.O. 1922, c. 60.

⁸S.O. 1951, c. 58.

⁹For statutory provisions relating to nursing in Ontario see S.O. 1961-62, c. 90, as amended by S.O. 1962-63, c. 92; S.O. 1964, c. 73 and S.O. 1965, c. 82; and O. Reg. 342/62.

tration examinations, the registration of successful candidates, and the discipline of registered nurses and registered nursing assistants. It is administered by a council which makes regulations under the Act, sets policies, and employs an administrative staff to carry out the statutory functions of the College. This council is partly elected and partly appointed. Elections are held every three years. The province is divided into twelve electoral regions and the registered nurses resident in each of these regions elect one member of the council for every 5,000 of their number or part thereof. In the election of June 1969, eighteen council members were so elected and partly appointed. Elections are held every three years. The province appointed by the Ontario Association of Registered Nursing Assistants (OARNA); and the Minister of Health, or his representative, sits as a member of council *ex officio*.

Since the establishment of the College, the RNAO has been changed to the status of a voluntary association representing the interests of those registered nurses in the province who choose to join it.

The RNAO is administered by a Board of Directors.¹⁰ Voting members of the Board are the president, president-elect, presidents of the fifty-eight existing chapters, and chairmen of the five provincial standing committees. The only non-voting member is the executive director of the Association who acts as secretary of the Board of Directors. The executive director is a permanent employee of the Association and is appointed by the Board of Directors.

There are three levels in the committee structure of the Association: chapter, region and province. The five standing committees — socio-economic welfare, nursing, educator, administrator, and finance — correspond at each level. The chairman for each committee at each level is elected from and by the members of the committee. The elected chairman at the chapter level serves on the regional committee; the elected chairman of the regional committee serves on the provincial committee; the elected chairman of the provincial committee serves on the Board of Directors.¹¹

The Role of Nurses

An extensive literature has been devoted to explaining what it is that "nurses" should do. Given the historical evolution of the practice of nursing, it is not surprising that this matter should be controversial. There is disagreement within the nursing "profession" itself as to what nursing should be; there is disagreement between nursing leaders and the employers of nurses on the same point. The latter seem to suspect nurse leaders and nurse educators of wanting so to define the practice of nursing as to justify unrealistically high standards of preparation, thereby unduly restricting the supply of nursing services available. The nursing

¹⁰Registered Nurses' Association of Ontario, *By-laws*, pp. 83-84.

¹¹Registered Nurses' Association of Ontario, reply to Questionnaire "B", Committee on the Healing Arts.

leaders, for their part, are apparently inclined to suspect employers of trying to keep nursing a subservient occupation for "trained" rather than "educated" practitioners.

Historically, the limits of nursing practice have been established by physicians. Both the general duties and the day-by-day orders that govern the nurses' work in a medical context have originated with physicians, in the first case through the directives of physicians' professional bodies specifying what tasks a physician may delegate¹² and, in the second, by the simple fact that the nature of medical practice makes it both necessary and convenient for physicians to dominate the nurse in her performance of her duties. Even in the hospital where the nurse is subject to a nursing and administrative hierarchy, and where she is regarded as an employee of the institution itself, the physician has in fact retained the right to countermand the orders of others and to issue orders directly to members of the nursing staff concerning the care of patients for whom he is responsible.

"Ideal" Statements of Nursing Functions

There are many general statements as to what should constitute the proper practice of nursing. One such statement proposed by the Canadian Nurses' Association includes the following points:

- 1) Giving nursing care and assisting with the rehabilitation of patients in all types of mental and physical illness, at home and in hospitals.
- 2) Assisting the doctor in carrying out the therapeutic plan of care through administration of treatments and medicines, as prescribed by the physician, and in observing significant developments in the patient's mental and physical condition and communicating these to the physician.
- 3) Teaching the principles and practice of health promotion and conservation, and providing health supervision and counselling.
- 4) Planning, administering, and supervising nursing services and participating in overall planning for health services insofar as nursing service is concerned.
- 5) Coordinating the various services available to the patient, in order that the best interests and welfare of the patient be safeguarded.
- 6) Organizing, administering and participating in the education of both professional and auxiliary nursing personnel.
- 7) Organizing, administering and participating in the activities of professional nursing organizations. These activities include the promotion of legislation for the control of the practice of nursing, the establishment of requirements for registration and the standards of nursing education, and the advancement of the economic welfare of nurses.¹³

There have also been attempts to go beyond comprehensive statements and to identify the essential core of nursing functions. Thus the 1966 Saskatchewan Ad Hoc Committee on Nursing Education took the position that "regardless of the number of specialized services, . . . a 'nurse is a nurse'".¹⁴ In support of

¹²See, for example, Report of the College of Physicians and Surgeons of Ontario, July 1967, p. 16.

¹³H. K. Mussallem, *op. cit.*, pp. 117-118.

¹⁴Province of Saskatchewan, *Report of the Ad Hoc Committee on Nursing Education*, Queen's Printer, Regina, 1966, p. 39.

this view, the Saskatchewan Committee argued that the prime concern of nurses is the provision of patient care, the "knowledgeable provision of comfort measures, predictably directed at reducing to manageable proportions the psychological and physical stress of discomfort," a function which is not the prime concern of others on the "health team".¹⁵ This view led that Committee to propose that there be only one category of nurse and one educational program for preparing nurses.

Against this stands the view advanced in one form or another by various spokesmen for nurses' associations, that, while there is a core of functions basic to nursing, these can be viewed as a continuum ranging from the simple to the complex, and that certain categories of nurses can be defined to deal with segments of this system. This is the view advanced by the Mussallem study on nursing education in Canada, prepared for the Royal Commission on Health Services in 1964.¹⁶ Mussallem contended that "on the basis of all evidence available, a review of all research and of present experience, the conclusion is that two categories of nurses are required to carry out the functions of nursing. These are two distinct categories of nurses, and should be prepared through programs which have different objectives".¹⁷

The two categories envisioned by Mussallem correspond to the technical-professional distinction favoured by leaders of the profession in the United States. Although at present more than four categories of nurses are now being formally prepared (not to mention the untrained workers who are frequently employed to do nursing work), her proposal is that formal preparation should be confined to producing a university-educated nurse trained to the baccalaureate level; and a diploma-level nurse educated in some other kind of post-secondary educational institute, such as a junior college. In her words, "these two programs would prepare all needed categories of nurses. The role to be assumed by the professional nurse implies she should have a professional education as a basis for developing a high level of professional and technical competence. This competence can be developed only if the practitioner has a sound understanding of scientific principles, as contrasted to the applied science which would be the basis for operation of the technical nurse."¹⁸

As to the respective division of the total nursing force between these two categories, the Mussallem study concluded that on the basis of available evidence, the university and diploma programs should be designed to yield a ratio of one graduate of the basic university program to three graduates of the diploma program.¹⁹

Another form of "ideal" definition of nursing functions is the comprehensive "legal" definition devised for use in statutes limiting the practice of nursing to qualified persons. A model widely used in the United States for this purpose

¹⁵*Ibid.*, p. 38.

¹⁶H. K. Mussallem, *op. cit.*, pp. 120-124.

¹⁷*Ibid.*, p. 121.

¹⁸*Ibid.*, p. 123.

¹⁹*Ibid.*, p. 125.

defines the "practice of professional nursing" as "the performance, for compensation, of any acts in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments prescribed by a licensed physician or a licensed dentist; requiring substantial specialized judgement and skill based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures."²⁰

Empirical Studies of Nursing Practice

Grades of Nurses. Many factual studies have been made of the specific tasks performed by nurses in their principal forms of employment. Ontario studies of this kind relate mainly to the work done by the following "grades" of nursing personnel employed in hospitals in Ontario. First, the least "formally qualified" of these are the orderlies, nurse's aides, "practical nurses", and psychiatric aides who perform a wide and ill-defined range of housekeeping, manual and other routine tasks in hospitals.

Second are the registered nursing assistants (R.N.A.), trained in ten-month courses to perform routine nursing functions, usually under the supervision of registered nurses (R.N.). The registered nursing assistant category was created during the 1940's in response to a serious shortage of fully trained nurses. The training program was initially sponsored by the RNAO, and in 1946 was taken over by the provincial Department of Health. Standards for registered nursing assistant training and registration of graduates are laid down in the Nurses Act.

The third and principal category of nurses, that which is usually thought of as comprising "professional" nurses, is the registered nurse category. Registered nurses are prepared to the standards required for registration by the College of Nurses of Ontario. They may hold a diploma or a Bachelor's degree in nursing. Either the diploma or degree nurses may have, as an additional qualification, a certificate in the recognized specialties of public health nursing, teaching or administration.

Finally, there are "trained" but not registered nurses. Usually these are nurses who have graduated from nursing schools abroad, but who are not eligible for registration because of some deficiency in their preparation as assessed by the College of Nurses of Ontario.

Employment Situations. Hospitals are by far the largest employers of all these categories of nursing personnel, but substantial numbers also are employed by various private and government-operated public health agencies.²¹ Much smaller

²⁰United States, *Report of the National Advisory Committee on Health Manpower*, United States Government Printing Office, Washington, D.C., 1967, Vol. 2, Appendix 10, p. 439 and Appendix 12, p. 452.

²¹See Chapter 6, Table 6.17.

numbers of nurses are employed by private business firms, government departments, physicians and dentists, and by private persons.²² The work done by nurses varies considerably from one of these employment situations to another.

Hospital nursing. In hospitals, nurses perform a variety of tasks, including direct patient care, curative care, administration, teaching, clerical work, and housekeeping duties.

Direct patient care entails evaluating the nature and extent of the care procedures to be provided to individual patients and the application of such procedures. The basic ones are feeding, bathing, positioning, skin care, giving exercise, aiding eliminations, keeping the environment quiet and orderly to facilitate rest and sleep, as well as specific procedures such as taking temperatures and blood pressure, administering medications, and changing dressings. There appears to be a growing awareness that, despite the apparent simplicity of some of these operations, the way in which they are carried out may have an important effect upon the patient's psychological condition, and that this can affect his physical comfort and possibilities for recovery. It is also recognized that there are certain specific psychological procedures to be followed in the course of providing direct care — procedures relating to the special needs of senile patients, of children, and of some other classes of patients. Despite this growing interest in these aspects of nursing, little progress seems to have been made in defining and establishing common principles to govern the psychological aspects of direct care.

A number of curative procedures are performed by the hospital nursing staffs, despite the view held by many nurses that this entire field should remain the province of the physician. At present, suitably prepared registered nurses in hospitals (and also in public health units and in some industrial services) are permitted, on the instruction of a physician, to administer intravenous solutions and medication, to perform rectal examinations on antepartum patients, to administer drugs subcutaneously such as uterine stimulating drugs to hasten or induce labour, to perform intracutaneous tuberculin tests, to administer immunization injections, and in "extreme emergencies" to administer certain anaesthetics.²³

Managing nursing units is a major function of many nurses in hospital employment. Such administrative work may entail recruiting and selecting employees, budgeting, staff scheduling, planning nursing care, and supervising the performance of staff work.²⁴

Nurses are employed in teaching many categories of health personnel in nursing schools, in registered nursing assistant training centres, and also in various short-course and in-service programs conducted in hospitals and public health units. In

²²V. V. Murray, *Nursing in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 9.

²³Registered Nurses' Association of Ontario, Brief to the Committee on the Healing Arts, 1966, pp. 21ff.

²⁴V. V. Murray, *op. cit.*, p. 13.

addition to such formal teaching, which is likely to be done by nurses with some special qualifications, ordinary hospital staff nurses may, as part of their own work, be responsible for advising and directing student nurses and junior staff members with whom they work.

The normal duties of nurses in the hospital entail considerable clerical work; they handle a great volume of information and records related to the admission and discharge of patients, the condition of patients, the control of drugs, laboratory tests, linens, and so on.

Various categories of nurses, even the more highly trained ones, spend part of their working time in performing housekeeping duties and in controlling traffic. They may be required to get and distribute supplies, medicines, linens, food trays; to clean; and to control the movements of patients, staff and visitors.

Studies have been made by the Ontario Hospital Services Commission (OHSC) to determine how these functions are actually allocated among the various categories of nursing personnel in hospitals in Ontario. Although it is necessary to interpret the findings of such studies with much caution, they do seem to support the claim that trained nurses are, in fact, required to do a good deal of work beyond what they themselves would judge to be the proper limits of their job. The studies referred to indicate that in 250 nursing units surveyed, 11 to 36 per cent of the nurse's time may have been spent doing work outside that provided for in the job classification used by the employing institutions.²⁵ These job classifications are themselves arbitrary, and in the absence of criteria by which to assess their appropriateness, statistics of this kind cannot be regarded as conclusive measures of inefficiency in the use of trained nursing staff. But on the assumption that most of the housekeeping, clerical, dietary and messenger duties performed by registered nurses and registered nursing assistants could be performed by less highly trained personnel, the studies conclude that registered nurses in hospitals misuse about 8 per cent of their time, and registered nursing assistants about 18 per cent of theirs.²⁶ It should be noted that these figures do not take account of the fact that the job classifications may not be the most appropriate ones.

Public Health Nursing. Public health nursing is a rapidly expanding source of employment for several categories of nursing personnel. As practised in government agencies, such as municipal and county health units, the work entails identifying public health problems, health education, immunization, and inspection of possible sources of disease. The employees of such agencies may work in maternal and child care clinics, in schools, in home visiting services, and in communicable disease control units.²⁷

There are also private and semi-private organizations involved in providing public health services. These include Children's Aid Societies, the Ontario Associa-

²⁵*Ibid.*, p. 205.

²⁶*Ibid.*, p. 206.

²⁷*Ibid.*, pp. 22-24.

tion for Crippled Children, the Canadian Cancer Foundation, Canadian Mothercraft Society, the St. John's Ambulance Association, the Canadian National Institute for the Blind, the Victorian Order of Nurses, and the St. Elizabeth Visiting Nurses Association.

All these bodies employ registered nurses who have special training in public health work, as well as others with R.N. and R.N.A. qualifications. The specially prepared public health nurses (that is, nurses with a basic R.N. diploma plus a one-year university certificate course in public health nursing, or an R.N. with a university degree) are relied upon in most of these agencies to undertake such tasks as planning nursing services, conducting family planning clinics, coordinating community health and social services, and providing follow-up services for recently discharged mental health patients. Registered nurses without special qualifications are also used extensively by some of these organizations to perform essentially the same activities, despite their lack of formal specialist qualifications.

Nursing for private employers. Business firms, private nursing homes, physicians, dentists and private individuals employ nurses of all types. The distinctive feature of these employments is that, while the hospitals and public health bodies all employ professionally qualified nurses in supervisory capacities, private employers usually do not. They are free to hire any kind of nursing personnel they choose to and, within the wide limits established by the Nurses Act, assign them to whatever task they wish. There is an exception to this in the case of some private employers who are required to hire registered nurses as some proportion of their staffs under the provisions of the Homes for the Aged Act, the Charitable Institutions Act, and the Nursing Homes Act 1966.

Conditions of Work in Nursing

The conditions under which nurses work are almost entirely determined by their individual employers. Consequently, there is no uniformity in these conditions of work even within the categories of employers described above, let alone among them. This would imply, of course, that nurses as a group have little power to influence their conditions of work and, at present, this does appear to be the case. The traditional status of the nurse in relation to physicians and the administrators of employing agencies has in the past militated against her having much effective say in determining what she could do, or how or when she should do it.

The wide variation in such practices would also suggest a lack of centralized control over the employers of nurses, and again this is generally the case. The principal exceptions are found in connection with working conditions in hospitals when these conditions have some direct and readily identifiable cost. Certain fringe benefit plans and pay scales, for example, may be contained within limits established for all employing agencies, subject to the control of organizations such as the OHSC.

Working hours are probably the most troublesome condition of nursing employment.²⁸ Most registered nurses in hospitals work eight hours per day for about twenty days a month. In many hospitals duty spans of seven or even nine days between days off are apparently not uncommon. Registered nursing assistants and orderlies in hospitals generally work a forty-hour week.

Most nursing employments involve shift work, much of which may often be badly organized from the nurse's point of view. The shift pattern in many hospitals is unstable and subject to change at short notice. The problems of scheduling shifts and days off is aggravated by the employment of part-time staff. Because of the scheduling problems such staff create, some hospitals try to avoid hiring part-time workers, others will hire them only if they will work the night shift or accept the same rotation as the full-time staff, and some will hire only part-time employees for a particular shift if they can be matched by part-time employees on the other shifts.

Vacations for nursing staff range from two to four weeks a year after six months' seniority, with a common pattern being two weeks a year with three weeks after some specified number of years, ranging from one to as many as ten in some hospitals. As in the case of shifts, scheduling vacations is frequently arbitrary and uncertain.

It is apparent from submissions made by nursing organizations and from the Committee's own commissioned study on nursing in Ontario that the allocation of working hours is a major cause of dissatisfaction on the part of nurses. In fact, the Murray study concludes that "problems in the allocation of time give rise to more dissatisfaction among rank-and-file hospital nursing staff of all classes than any other single issue".²⁹ This consideration has a number of important implications for the problems of attracting people to the practice of nursing and of keeping them active in it.

Problems and Issues of Nursing Practice

The Need for More Research into the Practice of Nursing

The fundamental difficulty in assessing the present state of nursing practice is that we know so little about the practice itself. There is little objective evidence available upon which to base judgments as to what is the proper scope of the practice, what classes of practitioners are required, what kind and amount of training each of these classes should have, or what forms of regulation are needed to protect the public against the possibility of being served by inadequately prepared practitioners. What "nurses" should do, how they should do it, how and to what level they should be trained and educated, and how the quality of their work should be guaranteed, are all questions which could be answered with any degree of certainty only by drawing upon an accumulated body of scientific knowledge concerning the practice of nursing.

²⁸*Ibid.*, pp. 68-70.

²⁹*Ibid.*, pp. 70-71.

This we do not have. Nor is there reason to believe that we will soon acquire it if we continue to rely upon the existing approaches to research in nursing. The Canadian Nurses' Association and the provincial associations of nurses lack the resources to undertake such work in any systematic way. Users of nursing services, such as the OHSC and the Ontario Hospital Association (OHA) either lack the resources to sponsor such work or doubt its usefulness. The diploma schools of nursing are not staffed with teachers who are either trained or motivated to do research. And even the university schools of nursing seem to be handicapped in the same way, if not to the same extent. As Murray reports, "at the present time it is fair to say there is not a 'research climate' in the university faculties of nursing." The reasons given for this include the burden of teaching, the major changes taking place in the structure of university nursing programs, lack of staff with adequate research experience, a lack of money, and lack of support from "related disciplines and other interested groups".³⁰

Given these circumstances, it seems reasonable to assume that if more research is to be done in the field of nursing, it will be necessary not only to reorganize it, but to justify the allocation of more resources to it.

The argument in favour of an expanded and reorganized nursing research program rests upon the expectation that its costs would be more than offset by increased efficiency in the use made of the resources which the community has allocated to nursing. If it could be demonstrated, for example, that work now done by registered nurses could be done just as well or better by less trained workers, or that registered nurses with specialized training could safely do work now done by physicians, more efficient use could be made of all this labour. The ultimate object of the research would be to discover means for improving the efficiency with which such health services are provided.

This case for more research into nursing practice was well presented in the brief submitted to the Committee by the University of Western Ontario School of Nursing. It recommended "that the existing conditions regarding nurse staffing in all types of situations where nursing is provided be revealed through survey research, such research to explore the problem 'round the clock', 'throughout the week', 'throughout the year'"; and "that optimum nurse staffing patterns be determined through experimental research, by carefully planned sampling, representative of all types of situations in which nursing care is provided, and that in this research the efficacy of nurse staffing patterns be established through their relative correlation with the calibre of nursing care provided, as objectively assessed"; and, finally, that subsequent to the implementation of these recommendations, "the needs and resources pertinent to provision of nursing care in all situations where it is provided in the province be explored scientifically, and that this be followed by a concerted drive to produce the maximum possible congruence between needs and resources".³¹

³⁰*Ibid.*, p. 201.

³¹University of Western Ontario School of Nursing, Brief to the Committee on the Healing Arts, 1966, p. 1.

Murray, too, recommends that a major program of research on optimum nursing resource utilization be launched as soon as possible, urging that the program should ideally be interdisciplinary and cover all types of employing institutions.³²

Recommendation:

70 That studies be undertaken by the Department of Health and the Council of Health on the role and relationships of professions and occupations in health care and that as part of these studies a continuing review of the appropriateness of the responsibilities of nurses and nursing assistants should also be undertaken.

The Council, in undertaking this review, should encourage the development of experimental programs to study how alterations in the role and functions of nurses could prove beneficial to hospitals or other agencies as well as to the nurses themselves. Such experimental programs would require the approval of the Department of Health whose budgetary support would be required. Studies of such a nature would require the collaboration of many people in the given study unit who would necessarily have to agree to any changes resulting in the nurses' responsibilities and work patterns. The Committee does not see that stringent rules should be laid down regarding what nurses may or may not do, but that nurses should work with other members of the health system in developing a team approach.

In addition to the improvement in efficiency which we expect would be possible as a result of such research into nursing practice, we would expect it to help minimize conflicts which still exist among nurses and other groups of health workers, and among different grades of nurses themselves. As suggested in Murray's study, where the services performed by nurses are interdependent with those performed by other groups, the nursing profession would be able to abandon its attempts to force an "artificial" separation from such other groups (if there were some objective means of determining appropriate areas of competence).³³ Within nursing itself, we believe that much could be done to increase efficiency and to eliminate obstacles to promotion and other internal nursing problems by developing recognized special qualifications for certain skills and areas of competence.

Clinical Specialties

We have proposed that research directed to defining the nature of nursing practice could be expected to make the use of nursing staff more efficient and to improve the relations between nurses and other health workers. We would also hope that it could lead to the further development and recognition of various specialties, such as operating room, obstetrics, eye and cardiac surgery, intensive care, and paediatric nursing, within the general practice of nursing.

³²V. V. Murray, *op. cit.*, p. 201.

³³*Ibid.*, p. 202.

Already a number of such clinical specialties are emerging as individual nurses acquire particular aptitudes and experience in the course of providing such specialized services. Nursing, medical and hospital spokesmen appear to agree that this is a desirable development. Even so, the development of clinical specialties in nursing is obstructed by the reluctance or inability of employers and professional nursing organizations to recognize such specialist qualifications. We believe that salary and rank recognition should be given to nurses with special clinical qualifications. Not only would this serve to encourage nurses to obtain such qualifications, but it would provide nurses with a means of advancing in their careers without having to rely upon administrative appointments for promotion. It might also serve to reduce turnover in nursing employments and to attract experienced nurses back into the practice of their profession.

Some nursing educators have envisioned the clinical specialist as a nurse trained to the postgraduate university level. The Faculty of the University of Western Ontario School of Nursing states that the apparent need for the clinical nurse specialist cannot be satisfied without the following:

- adequate educational preparation (we believe this to be at the graduate rather than the undergraduate level);
- prolonged clinical experience which makes her thoroughly familiar with the particular clinical field and effectively operational within it;
- provision within the organizational structure to permit her to function as as consultant in relation to nursing care;
- adequate remuneration for her services;
- precautionary measures to reduce nursing staff turnover.³⁴

The Ontario Medical Association suggests, on the contrary, that the clinical specialist need be only a diploma graduate with several years of on-the-job experience resulting in special competence in one area of nursing.³⁵ The Committee believes that in some cases specialties might be open only to degree nurses but that many specialties would also be open to diploma nurses.

The Committee is not equipped to determine the most appropriate form of preparation for the clinical nurse specialist. That can be determined only by experts who are closely acquainted with the needs and problems involved in this area of the health services; but it may include both formal didactic and clinical on-the-job training. We are convinced that steps should be taken to recognize and to increase the numbers of such specialists as quickly as possible.

Recommendations:

- 71** That clinical specialties in nursing be developed for diploma and degree level nurses, and that recognition be given by the College of Nurses and where appropriate by the Ontario Hospital Services Commission to

³⁴University of Western Ontario School of Nursing, Brief to the Committee on the Healing Arts, 1966, p. 12.

³⁵Ontario Medical Association, Transcript of the Hearings of the Committee on the Healing Arts, June 28, 1967, pp. 5270-5275.

such specialties. The Committee realizes that in developing such specialties nurses will require the assistance of physicians and hospital officials. The Department of Health should take the initiative in bringing together those involved to work out means of developing such specialties and providing recognition for them, including representatives of nursing, medicine and hospitals. While it would be advisable to develop these specialties through a "Royal College" type of specialty body at the national level, if this is not done, they should be developed at the provincial level for Ontario.

- 72 That any body recognizing clinical specialties should take into consideration the problem of nurses now practising who have many years of experience in a given specialty and should arrange for appropriate recognition of such experience. None of the new clinical specialties should require formal training longer than one year, and the training programs could vary from purely clinical for some specialties to largely academic for others, as well as various combinations of such training programs as may be deemed necessary.

The Committee would like to see attempts made to establish in Ontario the particular nursing specialty of nurse-midwife. An important supplier of maternity services in many countries, the trained midwife is not a legally recognized practitioner in most Canadian provinces, although nurses trained in midwifery do perform such work in many "outpost hospitals" in this country. The World Health Service describes the midwife as follows:

She is trained to give the necessary care and advice to women during pregnancy, labour and the post-natal period, to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times she must be able to recognize the warning signs of abnormal or potentially abnormal conditions which necessitate referral to a doctor and to carry out emergency measures in the absence of medical help. She may practise in hospitals, health units or domiciliary services. In any of these situations she has an important task in health education within the family and the community. In some countries her work extends into the fields of gynaecology, family planning and child care.³⁶

In the United States the "American College of Nurse Midwifery" defines a nurse-midwife as "a registered nurse, who by virtue of added knowledge and skill gained through an organized program of study and clinical experience, recognized by the American College of Midwifery, has extended the limits of her practice into the area of management of care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal".³⁷

The feasibility of employing such a specialist in Ontario, and the advantages

³⁶World Health Organization, *The Midwife in Maternity Care*, Report of a WHO Expert Committee, World Health Organization Technical Report Series, No. 331, 1966, p. 8.

³⁷See M. I. Crawford in *The American Journal of Nursing*, Vol. 63, No. 9, p. 130.

of doing so, were explored in one of the studies prepared for the Committee.³⁸ We are convinced that properly prepared and regulated nurse-midwives could relieve physicians of many duties involved in prenatal and postnatal care and also in deliveries. Such a nurse-midwife would work primarily in hospitals under the general direction of physicians, but also in the employ of group practices.

Recommendation:

- 73** That an attempt be made by the disciplines concerned and the Department of Health to develop a nurse-midwife in Ontario and that such a nurse-midwife be regarded as a clinical specialist in nursing. The Committee foresees that nurse-midwives would work in the hospital setting under the general direction of physicians but might in addition undertake pre-natal and post-natal care in outpatient clinics and group practices.

The Committee is aware that this may be one of the more difficult clinical specialties to establish. As with the other specialties, it will be necessary to clarify the legal status of nurse-midwife so as to avoid infringement of the provisions of the Medical Act. It will also be necessary to have the cooperation of the medical profession, of the public, and of nursing and hospital associations in developing these clinical specialties in nursing. The cooperation of the College of Physicians and Surgeons will be required to determine what functions may be delegated to nurse specialists. The cooperation of the public will be required, for without public acceptance of new roles for nurses, this specialist will have little chance of being useful. And the cooperation of nursing associations and hospital administrators will be needed to ensure efficient utilization of the services the specialists are able to supply.

While the above discussion on clinical specialties also applies to psychiatric nursing, the case of the psychiatric nurse is further examined in a separate section at the end of this chapter. We believe that psychiatric nurses have an important role to play in the care of the mentally ill, especially in face of the acute shortage of mental health workers in Ontario.

Relations of Registered Nurses with Other Groups

Relations with Registered Nursing Assistants

To the extent that there is a conflict between registered nurses and registered nursing assistants concerning the proper scope of their respective activities, some improvement in nursing practice might be effected by specific measures designed to minimize such conflicts. We have noted two possible measures proposed by Murray; to have the OARNA merge with the RNAO, or to have the Nurses Act amended to include registered nursing assistants as members of the College and to increase their representation on the Council of the College. It would seem, however, that the registered nurses themselves would prefer to see the registered

³⁸R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Ch. 8.

nursing assistant category eliminated altogether. The Special Committee on Nursing Assistants appointed by the Canadian Nursing Association reported in 1962, "that some type of wise, well-planned integration of the nursing assistant group into the registered nurse group is the eventual answer in meeting the nursing needs of patients and for keeping our profession in order" And the Faculty of the University of Toronto School of Nursing suggested in the course of the Committee's hearings that the registered nursing assistant's training could be brought up to a minimum registered nurse level.³⁹ We tend to agree with the College of Nurses, however, that before it will be possible to decide on this question, more work will have to be done to determine the ideal length of the nursing program covering the present minimum curriculum.⁴⁰

While the registered nursing assistants appear to be content with the present relationship between themselves and the registered nurses, the OARNA did recommend in its brief to the Committee "that the registered nurse in her basic training be taught what the role of the registered nursing assistant is, what her area of competence is, and the responsibility of the registered nurse in the allocation of assignments to, and the supervision of, the registered nursing assistant".⁴¹ The Association also suggested that the government, or "organized nursing", should plan and offer post-basic courses for registered nursing assistants, especially in psychiatric nursing and care of the chronically ill (including the aged).

The Committee is not persuaded that the RNAO and the OARNA should be encouraged to merge or that the registered nursing assistants should disappear. There remains a definite place for the registered nursing assistant, and we will make recommendations concerning the education and regulation of this group of workers later in this chapter.

Relations with Physicians

The traditional subservience of the nurse to the physician is one of the most fundamental relationships in the health services field. With the development of special technical nursing skills, however, and perhaps as a consequence of the changing status of women workers generally, it is becoming more important that nurses should have a say in determining how they do their work. The Committee regards increased consultation and cooperation between bodies such as the RNAO and the Ontario Medical Association as necessary and desirable.

A particular problem concerning the relationship between nurses and physicians is the matter of delegation of certain medical procedures to nurses. In this regard the University of Western Ontario School of Nursing has urged, for example,

³⁹University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, p. 590.

⁴⁰College of Nurses of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, February 20, 1967, pp. 493-496.

⁴¹Ontario Association of Registered Nursing Assistants, Brief to the Committee on the Healing Arts, 1966, p. 9.

“that there be exploration of and appropriate action taken in regard to the authorization, legal or otherwise, for nurses to carry out in some health agencies certain activities routinely considered to be the responsibilities of the physician”.⁴² There would seem to be a need to improve communications between the College of Nurses and the College of Physicians and Surgeons on such matters of nursing practice. Murray suggests that nurses should be able to initiate requests to have certain procedures delegated to appropriate classes of nurses and that they should be consulted when physicians initiate a change in such arrangements.⁴³

Relations with Employing Agencies

Participation in Decision-Making

The existing channels of communication between the nurses and the OHSC, the Ontario Hospital Association, and individual employing units do not appear to be functioning well. Murray’s study indicates that with respect to the OHSC, “nursing does not appear to be strongly represented in the process within the Commission which creates the policy guidelines used by hospitals”.⁴⁴ Many of these guidelines strongly affect the nature of nursing practice because they have to do with such matters as the design of hospitals, their budgetary policies, procedures concerning personnel administration, the assignment of departmental responsibilities and individual job description.

With regard to the relations between the RNAO and the Ontario Hospital Association, Murray’s report indicated that they are “badly shattered”.⁴⁵ And at the individual employing agency level, nurses appear to have little opportunity to participate effectively in the formation of policy. A relatively simple means of improving relations at this level would be to have nursing service directors sit on hospital Medical Advisory Committees and on the Executive Committee of each hospital.⁴⁶

Recommendation:

- 74** That nurses should be represented in planning and determining their own role and should be included on interdisciplinary committees where their functions are being discussed.

Salaries and Fringe Benefits

Nearly all nurses today are salaried workers. The practice of private duty nursing in return for fees, once a relatively important source of income for registered nurses, has now become a relatively insignificant source of employment for them.

As in the case of working conditions, the determination of nursing salaries is made by individual employers. Some uniformity is imposed in the case of hospitals,

⁴²University of Western Ontario School of Nursing, Brief to the Committee on the Healing Arts, 1966, p. 14.

⁴³V. V. Murray, *op. cit.*, p. 204.

⁴⁴*Ibid.*, p. 204.

⁴⁵*Ibid.*

⁴⁶See also Chapter 27.

however, because of the way the OHSC "informally" establishes maximum rates of pay for nurses through its procedures for approving the salary budgets of individual hospitals. Nevertheless, hospitals remain free to pay rates lower than those approved by the OHSC and to determine their own policies with regard to pay differentials for experience, special qualifications, overtime, and other considerations.⁴⁷

The OHSC maximum monthly starting salaries for various categories of nurses in 1968 were as follows:⁴⁸

Registered nurses (general duty)	\$445.00
Registered nursing assistants	\$325.00
Orderlies — trained (Toronto)	\$354.00
Orderlies — untrained (Toronto)	\$338.00
Aides (Toronto)	\$315.00

These basic rates may be augmented to allow for experience, although the practice in this regard is not uniform except for some recent standardization which has occurred in the registered nurse category. Many Ontario hospitals now meet the Toronto standard for "seniority" or "merit" increments. In 1967 these provided a registered staff nurse with sixteen dollars per month per year for five years. There is no such uniformity in the practice concerning such differentials for registered nursing assistants, aides and orderlies — rates for the latter groups being determined mainly by local labour market conditions.

Higher rates of pay are available for registered nurses in positions above that of the general staff nurse. Some of these positions may or may not require specialist qualifications. Nursing supervisors, for example, could receive up to \$727.00 per month. Such administrative positions also yield rewards for experience and possession of university qualifications. For example, in 1967 a university degree added about forty dollars per month to such administrative salaries. Nurses employed as instructors in nursing schools may also obtain salaries above the maximum for general duty registered nurses, although the range overlaps to such an extent that a general duty registered nurse with seniority may make more than an instructor at the bottom of her scale. Registered nurses with public health certificates had 1967 starting salaries ranging from \$408 to \$474 compared to the general duty registered nurses' average starting salary of \$400 in the same year.

A few hospitals in Ontario pay above the standard rates for nurses who have special qualifications for operating room or intensive care unit duties. Although this appears to be rare at present, there is much interest among nurses' organizations and nurse educators in developing special educational programs to prepare such clinical specialists. Employers also seem to be interested in encouraging the

⁴⁷V. V. Murray, *op. cit.*, p. 66.

⁴⁸*Ibid.*, p. 55.

development of this kind of specialization, although there is evidence to suggest that they tend to see much specialization coming about more as a matter of practical experience than through special educational preparation.

Nurses have not generally been given extra pay for shift work, although at present there is a move to implement such a practice. Beginning in 1968 the OHSC authorized hospitals to pay up to one dollar per shift extra to graduate nurses working evening and night shifts. Most nurses do not receive pay for over-time work, but instead are given equivalent time off.

Geographic differentials exist in nursing salaries. Within Ontario the major differentials occur in the lower-trained categories of nursing personnel, and least in the registered nurse category. This may reflect the relative lack of mobility on the part of the less highly trained workers compared to the great geographic mobility of registered nurses.

Even within the "general nurse" category of registered nurses there are some notable geographic salary differentials. An isolated northern town like Kirkland Lake, for example, pays above the standard rate for general duty registered nurses as does Windsor, which is forced to compete with Detroit salaries.⁴⁹

Interprovincial salary comparisons are difficult to make, but insofar as any generalization is possible, it would seem that general nursing salaries in Ontario in recent years have probably been the highest in Canada. British Columbia and Alberta averages may, however, be equal to or even beyond the Ontario levels at the time of writing (July 1969). International comparisons are even more difficult, but from an examination of 1966 data, it would appear that Ontario salaries have been about 7 per cent lower than salaries in the adjacent north central states.⁵⁰

Most hospitals and other large institutional employers of nurses in Ontario provide medical, life insurance and pension plans for their employees. As with working conditions and salaries, these benefits vary markedly from one employer to another, but the most general practice appears to be for employing agencies to pay 50 per cent of the cost of a life insurance plan, of a medical-surgical plan, and of a pension plan.⁵¹ Nurses employed in hospitals receive free medical attention.

Collective Bargaining

Dissatisfaction with salaries, working conditions, and role in employment situations have led many nurses to look to some form of collective bargaining as a means of improving their lot. Because nurses in some other provinces have gone much further in the development of collective bargaining procedures than they have in this province, the situation here should be placed in this broader national context.

In British Columbia, nurses have undertaken some form of collective bargaining since 1946. Until 1956 the certified bargaining authority was a special "select

⁴⁹*Ibid.*, pp. 61-62.

⁵⁰*Ibid.*, p. 63.

⁵¹*Ibid.*, p. 71.

committee" of the Registered Nurses' Association of British Columbia, but since then the Association itself has fulfilled this role. The Association applies for separate certification for each group of nurses that it wishes to represent, and collective bargaining is then pursued in accordance with the provisions of the provincial Labour Regulations Act. Since 1959 the Registered Nurses' Association of British Columbia has engaged in province-wide collective bargaining for nurses employed in hospitals, conducting its bargaining with the British Columbia Hospital Association. At present the Registered Nurses' Association of British Columbia is certified as bargaining agent for seventy-eight groups of nurses employed by sixty-two hospitals, thirteen public health agencies, one industry, one doctor's clinic, and one medical insurance agency.

The Alberta Registered Nurses Act was amended in 1966 to permit the Alberta Association of Registered Nurses to act as bargaining agent under the Alberta Labour Act when requested to do so by a majority of a group of its members working for the same employer. The Alberta Hospital Association has proposed province-wide collective bargaining for nurses employed in hospitals, but the Alberta Association of Registered Nurses has been hesitant to enter into such arrangements.

The Saskatchewan Trade Union Act was amended in 1966 to permit the Saskatchewan Registered Nurses' Association to act as bargaining agent for registered nurses in Saskatchewan, but the Association has preferred to seek passage of special legislation governing collective bargaining by nurses and is now drafting a bill for this purpose.

The Manitoba Association of Registered Nurses is prepared to act as bargaining agent for groups of registered nurses either on a voluntary basis, or by applying for certification under the existing Labour Relations Act. Such activity has begun only very recently in Manitoba.

The situation in Quebec is more complex than in the other provinces. The 1946 Act respecting the Association of Nurses of the Province of Quebec made provision for each nursing association in the province to negotiate collective agreements with employers. This right was not exercised until recently, when the English chapter of District 11, Association of Nurses of the Province of Quebec, organized the United Nurses of Montreal. At present, staff nurse associations are being organized and collective bargaining is in progress in some units. Several other organizations also bargain for certain groups of nurses in Quebec. *The Syndicats Professionnels des Infermieres Catholiques* represents some nurses in Quebec City, and the Metropolitan Association of Nurses of Montreal bargains for nurses located mainly in the Jewish General Hospital in that city.

In the Maritime provinces what collective bargaining does take place is on a voluntary basis only, although nursing associations there seem to be working towards a stronger position on collective bargaining.

The collective bargaining situation in Ontario is unique, because the existence of the College of Nurses means that membership in the RNAO is not compulsory; only about 22 per cent of registered nurses belong to the Association.⁵² Thus, the latter can hardly claim to speak for all the nurses of Ontario for bargaining or for any other purposes. The willingness of Ontario nurses to establish the College of Nurses in order to gain professional control over inspection of schools and other functions which, until then, had been retained by the Department of Health in this province, may reflect the nurses' ambiguous feelings about "professionalism" versus "unionism". They may consciously have chosen to weaken the "union" to strengthen the profession.

The existing situation in Ontario seems to be one of suspended animation. The RNAO has considered various methods which could be used for collective bargaining by nurses in this province, but it seems uncertain about the ultimate objective. The present arrangement for voluntary negotiation was adopted in 1958 "with the ultimate aim of securing legislation for compulsory arbitration if necessary".⁵³ This plan of voluntary negotiation is centred on the RNAO's nursing consultant in personnel relations, who assists nurses with their employment problems, and who gives assistance, on request, to groups of nurses in dealing with employment problems and acts as negotiating agent with their employers when necessary — that is, when it becomes apparent to such groups that their local efforts are not succeeding. Some nurses have been dissatisfied with this arrangement, however, and in 1962 the Male Nurses Committee of the RNAO openly stated that voluntary methods of negotiation were not proving to be effective.⁵⁴ Following an investigation of their situation, the Ontario nurses decided at their 1964 Annual Meeting to seek provincial legislation to provide for the right of registered nurses in Ontario to bargain collectively with their employers on all matters involving salaries and working conditions, with the RNAO to be recognized as the bargaining agent.⁵⁵

In view of the present uncertainty in the RNAO, the inability of the Association to speak for more than a fraction of the registered nurses in Ontario, and the possibility that some other groups of medical workers are in a similar predicament, we believe that in order to encourage the development of orderly procedures for the negotiation of equitable salaries and working conditions for nurses in Ontario, the provincial government should enact special legislation to permit groups of nurses to have the RNAO or other appropriate agencies act as their bargaining agent notwithstanding the present provisions of the Labour Relations Act. This would be a flexible arrangement which could either lead to the evolution of a more highly centralized system of collective bargaining for nurses some time in the future, or leave bargaining decentralized if desirable.

⁵²R. D. Fraser, *op. cit.* Appendix A, Tables A61 and A62.

⁵³Registered Nurses' Association of Ontario, "Collective Bargaining Progress Report", 1945-1968, p. 71.

⁵⁴*Ibid.*, p. 62.

⁵⁵*Ibid.*, p. 74.

Recommendation:

- 75 That the Province of Ontario enact appropriate legislation to facilitate collective bargaining for nurses, ensuring that in such legislation there are safeguards to maintain essential services and that the legislation also provides for compulsory arbitration of disputes. Such legislation should not specifically designate any agency as the exclusive bargaining agent for nurses but should be broad enough to encompass the Registered Nurses' Association of Ontario which might act as the bargaining agent when requested by the majority of nurses employed in a given bargaining unit.*

"Manpower" Considerations in Nursing**The Demand for Nursing Services**

The demand for nursing services is determined by several variables, the most important of which are the size and composition of the population, the extent of hospital and public health facilities, and the way nursing personnel are utilized by employers. As the population of the province grows, more nurses will be required. However, there is no reason to believe that there is a fixed ratio between the total population and the quantity of nursing care which the population will demand.

Because hospitals employ over 70 per cent of the registered nurses (and over 90 per cent of the registered nursing assistants), and public health agencies another 6 per cent of the registered nurses, the availability of these facilities to the general population will largely determine the total demand for registered nurses and assistants. The design of these hospital facilities and the staffing policies of hospitals and other employing institutions are also factors affecting the total demand for nursing services and the relative demand for particular categories of nursing personnel. Staffing policies are particularly difficult to analyze, for they are inseparable from judgments concerning the "quality" of nursing service.

Not only may various categories of nursing personnel be substituted for one another, but nursing staff can be substituted for other classes of health workers as well. Within the constraints imposed on employers by convention, technology, and availability of staff, some work of registered nurses may be done by registered nursing assistants, and some work of physicians may be done by registered nurses.

Trends in Demand for Nurses

Rough estimates of the overall demand for the existing categories of nurses can be made on the basis of measured hospital patient days, the ratio of nurses to patients in the hospitals, the hours of patient care provided per day, and the patterns of utilization of nursing personnel in the different categories. Such evidence as is available on these points suggests that in recent years the demand for

*See minority opinion, pp. 522-523.

TABLE 10.1
Nursing Hours of Care per Day and Distribution of Care Between
Nursing Department Personnel in Ontario Hospitals, 1964-1966

Hours of Care per Day	Percentage of Care Provided by Grad. Nurses (Reg. and Non-Reg.) ¹			Percentage of Care Provided by Qualified Nursing Assistants ¹			Percentage of Care Provided by Orderlies (All Levels) ¹			Percentage of Care Provided by Other Nursing Dept. Personnel ¹					
	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966	1964	1965	1966 (+ or -) 1964-1966			
GENERAL HOSPITALS															
Group A (Teaching)	6.4	6.6	6.9 + .5	53	53	54 + 1	13	13	13 0	9	9	9 0	24	25	25 + 1
Groups B and C (100 + beds)	6.1	6.2	6.3 + .2	52	54	55 + 2	18	19	19 + 1	6	5	5 -1	24	22	21 -3
Groups B and C (1-99 beds)	5.6	5.7	5.9 + .3	51	52	53 + 2	24.5	25	24 0	4	4	4 0	21	19	19 -2
Group D (4-22 beds)	5.4	5.7	5.8 + .4	60	68	63 + 3	30	29	30 0	2	3	7 + 5	8	0	0 -8
CONVALESCENT	3.9	3.9	4.0 + .1	38	37	41 + 3	20	18	17 -3	4	13	11 -3	29	32	30 + 1
CHRONIC	3.9	4.0	4.2 + .3	24	26	27 + 3	15	15	13 -2	10	10	9 -1	50	50	50 0
TOTAL: ALL HOSPITALS	5.8	6.0	6.2 + .4	50	51	52 + 2	17	17	17 0	7	7	7 0	25	25	24 -1

¹Rounded to nearest whole number.

SOURCE: V. V. Murray, *Nursing in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 83.

graduate nurses in the larger hospitals has been increasing more rapidly than the number of beds. The number of hours of nursing care per patient day has been increasing in these hospitals, and the proportion of this care being given by graduate nurses has also been increasing. In the smaller hospitals the percentage of patient care being given by graduate nurses has declined somewhat, with the difference being made up by other nursing personnel (see Table 10.1).

While the above evidence may lead us to believe that the demand for nursing services will continue to grow at a rate higher than the rate of population growth in the province, not enough is known about the other factors which may influence this demand to permit us to draw any firm conclusions in this regard. As with all health personnel, the demand for nurses is a derived demand. That is to say, because nursing services are an input in any medical care system, the demand for these inputs will reflect the demand for the final product: health care. Unfortunately, the demand for health care is difficult to analyze, for a number of reasons. For one thing, it is possible that demand is not independent of the supply of health care. Because this is a general problem in the study of all types of health practitioners, it will be considered elsewhere in our Report. The Committee recognizes, however, that most of the nursing labour force is employed by hospitals and other agencies subject to provincial government control.

Recommendation:

- 76** That the Department of Health and the Ontario Hospital Services Commission recognize that as hospitals and other public institutions are the primary employers of nurses and nursing assistants and hence are predominant in determining conditions of demand for nursing services including work environment of nurses, salary schedules, and so on, nurses are not working in an open labour market. That accordingly the Department of Health should take the responsibility to initiate intensive studies of the special features of this labour market and encourage adaptations to improve the conditions of employment of nurses.

The Supply of Nursing Services

Measures of Supply

The supply of nursing services is a function of the number of persons in the "nurse labour force" and the amount of "nursing" provided by each practitioner. Although there are some measures of nursing supply expressed in terms of "hours of patient care" in hospitals, most available data used in estimating the total supply of nursing services available rely upon simple measures of the number of practising nurses. These latter data are obtainable in raw form for registered nurses and registered nursing assistants directly as a consequence of the registration process. Data for other categories, such as aides and orderlies, are available from the hospital sources which account for most of their employment. No direct measures are available for those unregistered persons who provide nursing services outside hospitals and other large employing agencies.

If we confine ourselves to the recognized categories of trained nurses, in 1968 there were 59,115 registered nurses and 14,907 registered nursing assistants on the rolls of the College of Nurses of Ontario.⁵⁶ In addition there were more than 3,000 trained, but not registered nurses in the province, making a total of more than 77,000 trained nurses in Ontario in 1968.

Not all this potential trained-nurse labour force is actually employed. In 1967, 4,488 of the 54,492 registered nurses registered in Ontario were not resident here, another 12,718 were not practising and 10,607 were practising only part time. The employment status of the remaining 3,103 was not known. A similar breakdown for registered nursing assistants indicates that in 1967, of 14,011 registered nursing assistants on the Register of the College of Nurses, 8,348 were employed full time in nursing and 1,802 were employed part time.⁵⁷ A breakdown of the employment status of the graduate (non-registered) nurses is not available.

Reference is often made to comparative nurse:population ratios in discussions of the supply of nursing services. Because the definition of "nurse" is variable, and because of the problems created by the differences between potential and actual nursing supply referred to above, these comparisons must be treated with considerable skepticism. It is possible, nevertheless, to arrive at a rough nurse:population ratio for Ontario in 1967. If we used the employment status breakdown available for registered nurses, we would estimate that in 1967 there were some 28,943 "full-time equivalent" nurses in that category actually employed. Adding to this the estimated 3,000 non-registered nurses working in the province and the 10,150 registered nursing assistants employed in nursing, we arrive at a grand total of 42,093 nurses. Relating this to a population of 7,149,000 shows a nurse:population ratio of 1:169.⁵⁸ If the registered nursing assistants were excluded, the ratio would be 1:224. These ratios compare favourably with those estimated for a number of other countries, as indicated in Table 10.2, although it must be

TABLE 10.2
Comparison of Nurse:Population Ratios in Selected Countries

Country	Year	Nurse:Population Ratio
Sweden	1964	1:193
Denmark	1965	1:253
United States	1963	1:340
Canada	1963	1:375
United Kingdom	1964	1:402
New Zealand	1964	1:793
Philippines	1965	1:1,349

SOURCE: Based on Ontario Department of Health estimates.

⁵⁶See Chapter 6, Tables 6.12 and 6.19.

⁵⁷See Chapter 6, Tables 6.13 and 6.22.

⁵⁸Data supplied by Ontario Department of Health.

emphasized that the comparability of these data has not been established. If any conclusion can be drawn from such comparisons, it must be that Ontario is *comparatively* well supplied with nursing manpower.

Determinants of Supply

Changes in the total number of nurses working in the province come about as a result of a balance struck between recruitment and attrition. The principal sources of the additions to the profession are known: they are the Ontario schools of nursing and various out-of-province sources from which Ontario obtains trained nurses.

In recent years the output of registered nurses from the Ontario schools of nursing has averaged about 2,500⁵⁹ annually and the current expansion program initiated by the provincial government in 1965 was intended to make possible an annual class size of 5,100 by the early 1970's. After making allowance for an annual in-school attrition of 18 per cent, by 1973 this training program could be producing approximately 4,300 nurses annually. Current plans of the OHSC will add 2,400 registered nursing assistants to the trained nurse work force annually from 1968 onward. At present levels of enrolment in these programs, it appears unlikely that these projected numbers of nurses and nursing assistants will be realized.

The supply of nurses from out-of-province sources has assumed major proportions in recent years. The influx has grown from just over 1,300 in 1961 to over 2,400 in 1967. Of this latter number, 37.5 per cent came from other provinces, 25.3 per cent from the United Kingdom, 21.7 per cent from the Philippines, 4.4 per cent from the United States, and 11.1 per cent from other countries.⁶⁰

One other factor which must be considered in connection with the supply of nursing services available in the province is the use made of students to meet some of the service needs of hospitals. Some existing statistics of nursing manpower include this element (for example, the 1965 OHSC projections to 1970); others (such as the studies cited in Appendices I and II of the Murray report) do not. Because there is no available measure of the quantity of such student services expressed in terms of "full-time equivalents", it is difficult to judge the extent to which the adoption of a different educational system might create staffing problems for hospitals. It was estimated by Mussallem, however, that in Canada as a whole, as much as one-third of the total patient care in hospitals may be provided by "student nurses".⁶¹ It seems unlikely that the fraction is now so high.

While the recruitment to nursing in Ontario can be measured directly, attrition rates can only be estimated. The number who simply disappear from the profession

⁵⁹See Chapter 6, Table 6.14.

⁶⁰Canadian Nurses' Association, Research Unit.

⁶¹H. K. Mussallem, *op. cit.*, p. 65.

each year can be arrived at by adding the recruitment figures for one year to the previous year's total and comparing this to the measured total for this year. The difference between the two figures represents the number of nurses lost from one year to the next to the profession in Ontario. This number fluctuates considerably from year to year, and there are only four years of observation currently available; but the annual rate appears to average about 10 per cent.⁶² This means that more than 4,000 nurses could be lost annually.

This high rate of attrition creates a major problem of nursing supply, for it means that very large numbers of nurses must be trained each year just to offset the number who leave the province or the profession. It also creates problems for employers, many of whom find themselves having constantly to hire nursing staff. This has been suggested as one of the reasons employers generally seem to feel that there is a chronic shortage of nurses. Such a high rate of turnover is, of course, to be expected in what is an almost completely female occupation. Many nurses undoubtedly drop out of nursing because of marriage, pregnancy, and the desire to travel. Yet the mean turnover rate of full-time graduate nurses in hospitals in Ontario during 1965 was more than 57 per cent, and in some hospitals exceeded 100 per cent. These rates are too high to be explained by the fact that nurses are female, skilled workers. It would seem that there must be other forces at work which drive nurses out of the profession — factors such as relative salaries, working conditions, and opportunities for advancement.

The Research Unit of the Canadian Nurses' Association has conducted a national survey of turnover rates for full-time general duty graduate nurses, qualified nursing assistants, and orderlies in public, private and federal hospitals. This study, based on unpublished data for 1965 obtained through the Dominion Bureau of Statistics, indicated on a scale comprising the ten provinces and two territories that Ontario had the fourth lowest turnover rate for graduate nurses, the fifth lowest turnover rate for registered nursing assistants, and the highest turnover rate for orderlies. The same study indicated that within Ontario the highest turnover rates for graduate nurses were observed in the private hospitals and the lowest in the federal hospitals.⁶³

A limited study of turnover in Ontario public hospitals for 1966 performed by Murray revealed a great range of turnover rates, from 20 per cent to 110 per cent, but no clear patterns as between regions or size of hospitals.⁶⁴ Another study, done in Manitoba in 1965, indicated that the primary reasons for student nurses leaving after graduation were to gain experience and to attend university. Those who intended to leave the province after graduation indicated that their reasons were to obtain higher salaries or better working conditions, or to enjoy a better climate.⁶⁵

⁶²Department of Health, Research and Planning Branch, unpublished data.

⁶³V. V. Murray, *op. cit.*, p. 104.

⁶⁴*Ibid.*, pp. 106-107, Tables 24 and 25.

⁶⁵Province of Manitoba, Report of the Committee on the Supply of Nurses, Queen's Printer, Winnipeg, 1966, pp. 3 and 69.

If anything can be concluded from these studies, other than that more intensive research is also needed in this field, it is that not all the turnover of nurses can be condemned and that much of it will have to be accepted as inevitable. However, the very high differential rate of turnover observed in various hospitals of all kinds suggests that some reduction in turnover rates could be achieved through implementation of better and more uniform personnel practices throughout the province. The main hope for this would seem to lie in the possibility of improving the working conditions for nurses and to have hospitals adopt personnel policies which would encourage nurses to stay in particular employments. Several specific suggestions to this end are made by Murray; these include 1) development of the team-nursing concept, 2) providing better opportunities for in-service training, and 3) creating an actual "promotion ladder" in which nurses can obtain higher salaries and greater responsibility in technical and clinical specialties, as well as in administration. This last measure, he suggests, would provide a nurse with strong incentive to remain with a given employer.⁶⁶

The Adequacy of the Supply of Nursing Services

While employers, such as the Ontario Hospital Association, the provincial government, and sometimes nursing organizations themselves, speak of a "shortage" of nurses, there are no unambiguous measures of this shortage available. The measures of overall supply and demand that do exist depend upon a number of arbitrary judgments concerning *quality* factors. Thus, in measuring demand, we are forced to rely upon standards of judgment such as that there should be "3.5 hours of nursing care available per patient day", or that adequate care may be provided by "0.43 nurses per bed", if we are to arrive at an estimate of the number of nurses required to staff existing and proposed facilities. Yet such standards as these are not so objectively determined that they can be accepted by all who are affected by policy inferences based upon them.

Until the results of more adequate analysis of this problem can be obtained, it is necessary to rely upon a subjective assessment of the question. The situation was concisely expressed by Murray in the following extract from his study:

Is there a nursing shortage or not? If one's dream is to have a nursing staff of relatively low turnover, full-time, Ontario-trained women, then the answer is "yes", simply because there is at least a 50 per cent turnover rate, about 30 per cent of the graduate nurses work part time only, and anywhere between 10 and 20 per cent of them may have been trained outside the province (no one really knows this latter figure). If, on the other hand, the problems of constantly recruiting and trying to accommodate and train part-time and newly arrived staff are not considered more than a nuisance, and if, instead, one merely asks if there are enough nurses to meet minimum acceptable standards of care and show statistical improvement beyond these minima every year, then the answer is "no" — there is no shortage.⁶⁷

⁶⁶V. V. Murray, *op. cit.*, p. 226.

⁶⁷*Ibid.*, p. 108.

Problems Relating to the Supply of Nursing Services

Manpower Planning Facilities. Although there is no evidence to "prove" that there is in fact an overall shortage of nursing services in the province, there undoubtedly are specific shortages of certain classes of nurses and shortages of nurses in particular geographic locations throughout the province. But because no single body has been made responsible for studying the demand for and the supply of nursing services in the province, and because government policy-makers have apparently not felt that it was necessary to obtain such data in the past, we cannot at present determine the particular locations and causes of these shortages.

Recommendations:

- 77 That nursing manpower planning, for both immediate and long-range planning of the needs for nursing manpower, be included as a function of the Ontario Council of Health and of the Research and Planning Branch of the Department of Health.
- 78 That the Department of Health and the Ontario Council of Health undertake immediate and intensive study of nursing manpower availabilities and potentials including data on those presently not at work and apparent present requirements and uses of nursing personnel.

Provision of such a central planning body does not imply abandonment of this work at other levels. Existing manpower research groups associated with the OHSC, the Ontario Hospital Association, the Canadian Nurses' Association and the RNAO should be preserved and encouraged to work closely with the centralized research organization in the Department of Health. Their function would be to perform detailed studies and to provide expert advice and information in those areas where they have special competence and experience. Improved information gathering and analysis systems should be introduced to facilitate this work. Staffing data reported by hospitals should permit distinctions to be made between budgeted positions temporarily vacant and those chronically vacant. The College of Nurses should collect information relating to the qualifications of each registrant, previous work experience, and present employment status and area of residence. The possibilities of using computers to store, tabulate, and analyze such data relating to the supply of and demand for nursing services should be investigated. And, finally, new procedures for the dissemination of the results of such studies should be instituted. Much valuable research may be wasted because it goes to people who are unable to make effective use of it.

Measures to Alleviate Specific Shortages. Specific shortages of nursing staff may arise because of rapid hospital expansion in a particular community, the remoteness of geographical locations, the nature of the employment (as in the case of chronic care and psychiatric hospitals), inadequate output of certain specialized types of nursing personnel, or the season of the year; or because particular hospitals acquire bad reputations among nurses.

About all that can be done to deal with the first problem — that of temporary

shortages arising from rapid hospital expansion — is to concentrate recruitment efforts in such situations and to encourage the design of new nursing units which will reduce the numbers of staff needed. Insofar as recruitment campaigns are relied upon here, they should include provision for retraining programs, and the provincial government should help to provide the necessary financial assistance to particular hospitals and other institutions with retraining programs which undertake such programs. If the problem is one of geographic remoteness, the obvious remedies would be to provide higher salaries, longer vacations, and other inducements designed to attract nurses to such areas.⁶⁸

In the cases of chronic care and psychiatric hospitals, special short-term training courses may be required to increase the numbers of nurses and nursing assistants available for these particular employments.

Recommendation:

79 That if as a result of the growth of care in rehabilitative, convalescent, and chronic care institutions and homes for the aged, the need arises for special short-term training courses for registered nurses and registered nursing assistants, the Department of Health should arrange for the provision of appropriate training courses to prepare them for this special field of care.

With respect to shortages of other specialized nursing personnel, the main problems arise in the fields of public health nursing, teaching, and nursing service administration. These are all areas of specialization which require some university training and, as we shall see when we discuss the problems of nursing education, the output of the university schools of nursing in Ontario is extremely limited. We will make recommendations concerning this important problem later in this chapter.⁶⁹

Summer shortages of nurses are often an acute problem in some hospitals. We believe that more could be done to encourage nurses to avoid leaving their jobs during the summer months through a system of higher summer pay, and by offering longer vacations if taken at times other than summer.

The problem of bad reputation arises as a consequence of the substantial degree of independence which individual hospitals in the province have in formulating their personnel policies. Again, this would seem to be something we may expect to see improve as a consequence of our recommendations concerning collective bargaining and more adequate provision for advising and assisting hospitals in the province, particularly on matters of personnel utilization.⁷⁰

The Problem of Attrition. While much has been said of how inefficiently nurses are used when they are employed, an even costlier problem is that so many of them are not employed at all. A large part of the total number trained

⁶⁸See Recommendation 81.

⁶⁹See Recommendations 92, 95 and 96.

⁷⁰See Recommendations 75 and 80.

is not in nursing employment. The need for investment in new training facilities could be reduced to the extent that this rate of attrition could be reduced. The Committee approves of the efforts made by local agencies to re-employ some part of the 13,000 or more trained nurses in Ontario who are not employed or otherwise employed, and we would hope such programs could be expanded. The work currently being done in the Research and Planning Branch of the Department of Health to ascertain means of attracting non-practising nurses back into the nursing labour force is important to this end.

Utilization of Nursing Supply. The Committee also believes that much could be done to improve the efficiency with which the existing supply of nursing services are being utilized by hospitals and other large institutional employers of nurses. We have already recommended that continuing studies of nursing utilization be undertaken and that the labour-market research activities of the central research unit of the Department of Health take the initiative in promoting this type of research.⁷¹ We also believe that the work of the OHSC could be made more effective in this regard. The Committee notes that the existing OHSC consulting service is handicapped by a lack of staff, and by the fact that this staff functions in the dual capacity of insuring that the hospitals adhere to OHSC requirements and of helping the hospitals to improve their standards of care at the same time. Because of this, it would seem desirable that the hospital inspection and consulting functions of the OHSC be separated, and that the consulting department concern itself with developing more comprehensive guides relating to health care standards and the efficient utilization of nursing personnel in the provision of care to meet these standards.

Recommendation:

- 80** That the inspection and consulting services of the present Ontario Hospital Services Commission be augmented under the proposed Ontario Health Services Insurance Commission to effect more systematic and comprehensive development of health care standards and personnel utilization across the province. Special attention by this unit should be given to the development of administrative procedures which would make possible greater utilization of part-time properly qualified nursing staff.

A "Nursing Reserve" Group. The province of Alberta has implemented a system for obtaining the services of retired nurses who do not want to commit themselves to working regular hours, even on a part-time basis, but who are still willing to do some work. A pool of reserve nurses is established similar to the supply teachers used by the public schools; these persons can be called upon in emergencies, or to overcome shortages due to unexpected absenteeism, turnover or summer vacations. In the Alberta system the reserve nurses are organized in their own association, provided with refresher courses, and given distinctive uniform identification. It is suggested that the psychological benefit of this group structure creates a higher level of morale among those nurses than does the present system

⁷¹See Recommendations 70 and 76.

of person-to-person recruiting of retired nurses. The reserve nurse system could be organized within the Department of Health, possibly on a regional basis so as to make implementation of the plan the responsibility of an appropriate regional body.

Recommendation:

- 81** That the Department of Health should make an effort to rationalize the use of nurses and to attract into employment some of the qualified nurses not now in practice. Steps should also be taken to determine what could be done by use of incentive and salary differentials to facilitate greater opportunities for part-time work in hospitals for nurses, to encourage nurses to take holidays in off-seasons, and to attract nurses into specific types and geographic areas of nursing where there are particular shortages. The Province should consider also the establishment of a Nursing Reserve Group possibly on a regional basis similar to that developed in the province of Alberta.

Measures to Increase Overall Supply of Nurses in the Province. Despite the lack of objective evidence to support the contention that a shortage of nurses exists, many groups have expressed concern that too few nurses will be available to meet the demand for nursing services in the province in the future. Nurses' organizations point out, for example, that a decreasing proportion of total high school graduates select nursing for a career. Hospital administrators complain of a chronic shortage of nurses, and the Ontario government has based its program for expanding the training facilities available for nurses on the assumption that such a shortage does exist. The Committee, for its part, has been impressed by the fact that Ontario is heavily dependent upon importing nurses from other parts of Canada and from abroad to meet its nursing requirements.

Various measures have been proposed to draw more people into the occupation of nursing:

- 1) Nursing groups have committed themselves to collective bargaining as one method for achieving this, and the Committee has taken this into account in recommending measures to promote collective bargaining for nurses in this province. It is hoped that the creation of orderly collective bargaining procedures will help to eliminate unwarranted inequities in wages, hours, and working conditions among employing agencies. It may also be expected to improve the overall salary position in nursing, both on a basic, across-the-board basis, and also by inaugurating differentials for shift work, overtime and holidays, by raising the maxima which can be paid at each level and by widening the differences between levels.
- 2) Another way of attracting more people into the nursing occupation could be to make it more attractive to males. It has often been pointed out there is a large untapped supply of potential nurses in the male segment of the population, but to date there have

been no effective programs designed to provide men with either the opportunities or the incentives to seek a career in nursing. (Psychiatric nursing has attracted more males than other fields of nursing.) Most nursing schools in the province discriminate against male applicants, especially in hospital schools where there has not been appropriate residence accommodation for males, and the existing nursing organizations appear to be doing very little to promote a new "image" for the man who goes into nursing practice. More opportunities for the preparation of male nurses may be found in the developing Colleges of Applied Arts and Technology, which may prove more adaptable to this purpose than the existing hospital, and even university, schools of nursing.

- 3) Because all registered nurses must pass through the existing educational programs before they can practise, any measures to streamline the functioning of these educational facilities could be expected to increase the number of trained nurses available in the province. For reasons already indicated, it is difficult to separate the question of the numbers of nurses graduated from the question concerning the quality of their education. The higher the educational requirements, the greater the barrier between potential entrants to the occupation and the numbers who finally get into it. Murray points out that if we accept the view of most nursing experts that nurses specializing in teaching, administration and public health require some formal educational preparation beyond the diploma level, the principal bottleneck in the production of sufficient numbers of qualified nurses will be the university school of nursing. In the case of teachers, for example, it appears that if nursing schools in Ontario expand in accordance with existing plans, at least 300 new teachers will have to be produced by the university schools of nursing by 1971. Yet, as we have seen, the university baccalaureate programs are not developing rapidly at all, and the elimination of the one year certificate courses further aggravates the problem. Thus, Murray contends that "without doubt the slow development of university programs in nursing is the most serious problem in nursing education today".⁷² Our recommendations concerning such educational matters will be made in the following section.

Nursing Education

Present Patterns of Nursing Education

One of the distinguishing features of the nursing profession is the great variety of ways in which nurses obtain their training. There are at present three main types of programs: the R.N. diploma programs; the Bachelor of Science in Nursing

⁷²V. V. Murray, *op. cit.*, p. 230.

programs; and the "post-basic" programs. Each of these comprises more than one variant. The most complex is the R.N. diploma program, which can take one of five distinct forms: it may be a three-year hospital-based course in which formal instruction is interspersed with hospital service; a hospital-based two plus one course, in which all the basic training is done in two years, with the third year being in effect an "internship" year given over to hospital work not under the school's direction; a two plus one course offered by a regional nursing school; a straight two-year hospital-based course; or a two-year course offered by an independent nursing school or by a College of Applied Arts and Technology.

The Bachelor of Science in Nursing programs may be taken in the form of a basic five-year course, in which two years of university are built onto a diploma course taken at an acceptable nursing school; they may be a four-year "integrated" course taken entirely at a university; or they may involve taking two or three years at university following an independently obtained diploma.

The post-basic program may be a one-year university certificate course in public health, administration, or teaching; or it may be a Master of Science in Nursing degree, offered at present only by McGill University and the University of Western Ontario.

R.N. Diploma Programs

Schools of Nursing

Although the number of schools offering the different courses is changing rapidly, at the time of writing (July 1969) there were seventy-two nursing schools, of which fifty-two were hospital schools, eight were "regional schools", four were independent of hospitals, and eight were university schools of nursing which provided registered nurse training as part of their degree programs. The regional schools referred to are increasing rapidly in numbers in accordance with the previously referred to provincial government policy for increasing the output of nurses. Because it was found difficult to expand existing large hospital schools rapidly enough to meet the government's planned nursing output of over 5,000 per year by 1970, a scheme was devised to establish new schools so located as to permit them to make use of the clinical facilities available in smaller hospitals, none of which would alone be large enough to support its own nursing school.

Both the curriculum and the pedagogy in these nursing diploma schools tend to be more uniform than might be expected from their number. All types of nursing schools in the province favour the so-called "modern" approach to the teaching part of their programs. This approach, while difficult to define precisely, emphasizes the teaching of principles, the intermixing of instruction and practical work, the division of the material into rather broad categories, and the inclusion of a good deal of social science in the curriculum. The major pedagogical differences seem to lie in the amount and distribution of "practice" which the student is exposed to during her course of training.⁷³

⁷³*Ibid.*, p. 135.

The "old fashioned" three-year schools tended to cram most of the didactic teaching into the first year of the course, so as to get students ready for service on the wards as quickly as possible. Nurse educators have long complained that this emphasis on preparing the student for immediate service amounted to a substitution of "training" for "education", and that the ward experience itself tended to be chosen more for its service value than for its instructional value. The newer two-year and the two plus one-year programs, on the other hand, provide a more selective type of ward experience and relate it to the classroom and laboratory work being done by the student as she progresses through the course. Only at the end of the course is the student put into general duty nursing. Thus, only about six weeks of "regular" nursing experience is provided in the two-year courses, whereas most of the third year is available for this in the three-year course. Although there is much controversy over the merits of these different approaches, there does not appear to be a major difference in the ability of the nurse to perform the duties assigned to her once she has been in regular employment for at least a few months. Indeed, one of the more remarkable characteristics of the existing complex system of nurse education is that there appears to be so little variation in the functional capacities of nurses trained in the different types of programs.⁷⁴

Other important, if less conspicuous, differences found among the various types of diploma schools include the following: 1) a growing number of regional and two-year schools are making use of instructors from colleges and universities to give basic sciences and social sciences, whereas in the older schools nurses and physicians typically did all the instructing; 2) some of these schools are much better provided with clinical facilities than others, with the independent schools located in smaller centres being particularly handicapped in this regard; and 3) their admission requirements vary. Although minimum admission standards for all diploma schools are set down in the Nurses Act, almost all of the schools require standards above this minimum. The basic requirement at present is that the applicant have grade twelve of the four-year (non-university entrance) program with standing in grade ten mathematics, in chemistry, and in either physics or biology. Most schools, however, require a 60 per cent average in grade twelve; some (including all the two-year schools) require partial grade thirteen standing; and some give preference to applicants on the basis of their high school standing. The Committee notes that under this system it is possible that once the school has filled up its available places, students applying for admission may be rejected, even if they meet the minimum academic requirements. This results in an unnecessary wastage of potential entrants to the nursing profession.

Recommendation:

- 82** That a central clearing house for applicants to schools of nursing in Ontario other than university schools of nursing be established by the Department of Education with appropriate analysis of sources of appli-

⁷⁴Murray discusses this in some detail. See V. V. Murray, *op. cit.*, pp. 146-151.

cations and follow-up research being made as required, and that the university schools of nursing establish a corresponding system for applicants to university schools of nursing.

Some non-academic admission requirements also are imposed by nursing schools. All nursing schools are required by the Nurses Act to obtain a medical certificate of good health from applicants, and most schools require a minimum age of seventeen, with some refusing to accept students over thirty. One school in Toronto will accept only applicants between the ages of thirty and fifty. Many diploma schools will not consider male applicants at all; some will consider them only if a certain number of such applications are received. Most schools require a personal interview; some also require a letter of reference and impose aptitude and achievement tests. Qualifications of faculty also vary among the different schools. Again, a minimum qualification is laid down by the Nurses Act, but some schools have more highly qualified teachers than others. The minimum requirement is that a teacher in a registered nursing diploma school be a registered nurse, that she have two years' experience in nursing, and that she be a graduate of a one-year university course in teaching or its equivalent. But many diploma schools, especially the newer two-year schools, employ teachers with considerably higher formal qualifications, usually a Bachelor's degree in nursing. While there is clearly a trend towards such higher educational qualifications for teachers in nursing schools,⁷⁵ there are still some teachers who lack even the formal minimum qualifications required by the Nurses Act. Nursing organizations work hard to promote the idea that the nursing schools should have more highly educated staff, and this is consistent with the long struggle of nursing leaders to strengthen the didactic element in the preparation of nurses. Progress in this direction has been obstructed, however, by the very small capacities of the university nursing programs from which teachers as well as other specialists in nursing must be obtained.

Output of Diploma School Graduates

Diploma school programs for registered nurses have grown only modestly since 1965. In that year the provincial government adopted a policy designed to expand the output of registered nurses in order to overcome an apparent shortage of nurses in the province. The target for this program was set at 5,000 graduates per year (sometimes it is reported to have been 5,100) by 1971, approximately twice the output achieved in 1965.⁷⁶ The policy of establishing a large number of new regional schools of nursing as part of this program suggests that an important factor thought to account for the inadequate output of nurses was the capacity of existing training facilities. It is interesting to note in this regard that in the United States it appears that the output of nurses has in recent years fallen below the

⁷⁵See Chapter 6, Table 6.16.

⁷⁶Murray explains at length why this policy was slow to show results. See V .V. Murray, *op. cit.*, Chapter 10.

capacity of existing training facilities. If the experience of the last few years in Ontario can be taken to indicate any such tendency, it might suggest that a similar phenomenon will be observed here. Unfortunately, not enough is known about the various factors governing the output of nurses in this province to enable us to be certain whether output is lagging because of inadequate training facilities, or because of a shortage of young women willing and able to gain admission to them. In the case of the United States, the report of the Health Manpower Commission states unequivocally that "in contrast to the situation for physicians and dentists, the present and the projected shortages of nurses do not reflect a shortage of training facilities . . ." ⁷⁷ Instead, the report suggests, there is reason to believe that nursing is simply becoming a relatively less attractive career for young women. The same has been said to be true in Canada. Mussallem points out that in 1940 about 25 per cent of female high school graduates in Canada enrolled in a school of nursing, whereas this had fallen to 20 per cent by 1950, to 10 per cent by 1960, and to less than 8 per cent by 1967. "Each year," she writes, "the figure declines and unless drastic changes are made, we can look forward to about 5-6 per cent . . . of female high school graduates entering nursing" ⁷⁸ Because the number of female high school graduates is increasing relative to our total population, this is not so alarming a prospect as it may at first sight seem. However, it is possible that nursing is becoming a less attractive occupation.

Possible reasons for a declining popularity of nursing could include uncertainty concerning the nature and purpose of modern nursing practice, relative wage rates and working conditions compared to teaching and other alternative occupations, and, in the case of the diploma training program, increased participation in university or other post-secondary institutions of higher learning by young people. ⁷⁹

Recommendation:

- 83** That considering the degree of dependence on registered nurses coming to Ontario from outside the province, the Province of Ontario should do everything possible to keep the diploma schools of nursing filled in order that it may be assured of an adequate continuing domestic supply of nurses. Because of the evidence received by the Committee that full use is not being made of all the schools of nursing, we recommend that measures be undertaken to attract more students into nursing by making salaries and working conditions for graduate nurses more attractive.

Control of R.N. Diploma Schools

Individual diploma schools enjoy considerable freedom to determine their own curriculum content, methods of teaching, and staffing policy. Formal constraints

⁷⁷United States, *Report of National Advisory Committee on Health Manpower*, Vol. 1, *op. cit.*, p. 22.

⁷⁸H. K. Mussallem, "Manpower Problems in the Nursing Profession", in Canadian Medical Association, *Medical Care Insurance and Medical Manpower, Conference Manuscripts*, 1967, p. 186.

⁷⁹See R. A. H. Robson, *Sociological Factors Affecting Recruitment into the Nursing Profession*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964. Also V. V. Murray, *op. cit.*, p. 160.

are imposed by the Nurses Act, which establishes certain minimum standards governing these and other matters, such as admission requirements, faculty qualifications, and course structure. The College of Nurses is responsible under the Nurses Act for ensuring that various schools adhere to the minimum standards, but in practice the supervision appears to be rather perfunctory.⁸⁰ Immediate financial control is exercised over the hospital schools of nursing (and the new regional schools) by the hospital or regional "school" boards concerned. Ultimate financial control is exercised by the OHSC which has the power to approve or disapprove the budgets of hospital nursing schools, not only in total but in regard to the specific items comprising them.

While the Committee realizes that some variation among schools preparing diploma-level nurses may be desirable, the existing differences in program length, clinical experience component, curriculum, and instructional standards, seem unplanned and, in some instances, excessive. We believe that a more effective system of centralized supervision and planning of diploma-level nursing programs could improve the quality and the efficiency of these programs.

We have considered a number of approaches through which such a rationalization could be effected. One possibility would be to leave the existing system of control much as it is but to improve coordination within it. The OHSC and the College of Nurses could be left with their present areas of responsibility and some system of joint policy-making could be devised to enable them to apply more uniform standards and procedures upon the diploma schools. There may be reason to doubt the effectiveness of this approach, however, because it would not substantially increase the amount of "official" pressure which could be brought to bear upon the individual schools.

A second approach would be to increase the authority of both the OHSC and the College of Nurses, so that they could require schools to expand, contract, close or merge; standardize their course content, admission policies, and so on.⁸¹

A third system of control would make one body responsible for all matters relating to nursing education. Representatives of the employers of nurses, especially the Ontario Hospital Association, seem to favour placing the education of nurses under the direct control of the Department of Health, on the grounds that this would eliminate much of the possibility that nursing leaders might attempt to unduly restrict entry to the profession by establishing excessively high standards of education required for it.⁸² It has been suggested that the Department of Health, or some branch set up within it, might be made responsible for the education of all paramedical practitioners, including nurses.⁸³ Yet another approach was sug-

⁸⁰University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, p. 644.

⁸¹V. V. Murray, *op. cit.*, pp. 232-233.

⁸²Ontario Hospital Association, Transcript of the Hearings of the Committee on the Healing Arts, June 21, 1967, pp. 4986-4992.

⁸³V. V. Murray, *op. cit.*, p. 233.

gested by the Ontario Medical Association in its brief to the Committee, when it proposed that the provincial government establish a Foundation of Nursing Schools to function as a governing body, having financial responsibility for the building and operation of all schools of nursing in the province.⁸⁴

Although the Department of Health might be considered the obvious body to be entrusted with the education of nurses, the Department of Education is even more suitable. The latter judgment would appear to be supported by a number of authorities and precedents. The Hall Commission recommended that nursing education in Canada should be organized and financed like other forms of professional education. In Manitoba the Minister of Health's Committee on the Supply of Nurses recommended in 1966 the establishment of a unified program "under the aegis of the Department of Education" and the "gradual phasing out" of the hospital schools of nursing.⁸⁵ In Saskatchewan the 1966 Ad Hoc Committee on Nursing Education recommended that the program of nursing education in that province be administered through a division of the Department of Education.⁸⁶ And of New Brunswick, in *Portrait of Nursing*, Katherine MacLaggen wrote, "It was felt that no defence was needed for moving the education of nurses into the Department of Education there, so long as the educational goals are preserved without conflict over other goals."⁸⁷ The latter reservation is an important one, however, for there are reasons to fear that under such a system, the nursing schools might lose touch with the sources of nursing practice. This may already have been a problem in some university-based schools of nursing.⁸⁸

Such considerations as the latter have led some authorities to oppose vigorously the approach to nursing education implied by placing it under the direction of the education authorities.⁸⁹ As mentioned above, the Ontario Hospital Association, appearing before the Committee, rejected the idea of training nurses in an educational setting in favour of having all paramedical training given in a hospital or medical school environment.⁹⁰ Murray suggests that beneficial results could be expected, "if the education of all other health service occupational groups requiring post high school training but not requiring university degrees could be brought under one wing — a Health Services Education Branch, for example".⁹¹ He suggests that under such an arrangement it might be possible to

⁸⁴Ontario Medical Association, Brief to the Committee on the Healing Arts, May 1967, p. 12.

⁸⁵Province of Manitoba, *Report of the Committee on the Supply of Nurses*, Queen's Printer, Winnipeg, 1966, p. 108.

⁸⁶Province of Saskatchewan, *Report of the Ad Hoc Committee on Nursing Education*, Queen's Printer, Regina, 1967, pp. 9-10.

⁸⁷K. MacLaggen, *Portrait of Nursing*, New Brunswick Association of Registered Nurses, Fredericton, New Brunswick, 1965, p. 3.

⁸⁸See "Problems and Issues in Collegiate Nursing Education" in F. Davis, *op. cit.*, pp. 138-175.

⁸⁹See, for example, Dr. Thomas Hale, "Clichés of Nursing Education", *New England Journal of Nursing*, Vol. 278, No. 16, April 18, 1968, pp. 879-886; and University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, pp. 247-249.

⁹⁰Ontario Hospital Association, Transcript of the Hearings of the Committee on the Healing Arts, June 21, 1967, p. 4992.

⁹¹V. V. Murray, *op. cit.*, p. 234.

devise common basic courses in health and social science which all types of students would take together during an initial period of training. He appears to envision in this regard, however, the provision of such training in an educational rather than in a hospital setting.

We have weighed these various proposals and find that we can support the general case for basing diploma nursing education in an educational rather than a service-related setting. In reaching this position we have recognized that nursing education in North America is changing rapidly in response to fundamental alterations in the nature of nursing practice and in the status and expectations of working women. A strong case is made by nursing leaders, such as the late K. MacLaggen, when they claim, as she has, that:

. . . it is taken as understood that an educational purpose does not rest on . . . skills alone. In this culture, everyone is a human being first and an employee second. For this reason, there must be a reasonable proportion of time and energy devoted to general education privileges.⁹²

This position raises a number of important policy conclusions:

- 1) The "general educational privileges" referred to will entail instruction in subjects other than technical nursing subjects. Because nurse teachers are not versed in these other subjects, specialists must be used to teach them. Such specialists are unlikely to be attracted to specialized schools of nursing, nor would the latter likely to be able to justify their full-time employment even if they were available.
- 2) It seems reasonable to assume that such a general education can best be attained in an educational environment occupied by students of diverse interests (and both sexes) rather than in an occupationally specialized training establishment for women. This point is explicit in the term "cloistered" school used by some nursing leaders to describe specialized nursing schools. It is understood that such cloistered schools do inculcate a spirit of dedication to the institution they serve, thus serving to attract the nurse to these institutions and to reduce the likelihood that she will put her professional ties (for example, to the nursing association) ahead of her affiliation to the institution where she obtained her training. All of this is compatible with a romantic spirit of service and dedication somewhat at odds with modern professional attitudes, perhaps, but still important to many nurses. The main objection to such a hospital-oriented approach is, however, that "education and service have interests which are conflicting (and that) when one agency controls both, the resulting juggling can only be detrimental to education".⁹³

⁹²K. MacLaggen, *op. cit.*, pp. 103-104.

⁹³*Ibid.*, p. 83.

- 3) An opposing principle is that the public's interest in the economically efficient production of the required numbers of trained professional or semi-professional workers must supersede the educational requirements of the individuals involved in the training process (especially when the latter is heavily subsidized by the community). Again, this statement cannot be "proven" by any evidence. But it can be opposed, as it is by MacLaggen, on the grounds that it is incompatible with a broader pattern of social thinking prevalent in North American society today — a society in which young people ". . . are not as restricted in educational opportunities as in the past . . ." and one in which they "need not continue to be satisfied with a system of education which is divided against itself because of service commitments and which requires its members to be largely self-educated."⁹⁴

Major departures from the traditional cloistered approach to nursing education have been initiated in a number of Canadian provinces and in the United States. Most of these involve the development of new, and usually shortened, courses of preparation for diploma level (or associate degree level) nurses. They have not been "revolutions" in nursing education marked by the sudden extinction of existing facilities, but rather an expansion of alternatives to traditional forms of nursing education, usually accommodated in multi-purpose educational institutions.

In Canada, the possibility of such innovation was long hampered by the absence of post-secondary institutions of the type found in the United States, the junior colleges, community colleges, and post-secondary technical institutes. Experimental nursing programs have been established in this country in isolated hospital schools, in centralized nursing schools, and in institutions such as the Ryerson Institute in Toronto. The latter is particularly interesting because the experimental program there was sponsored by the Registered Nurses' Association of Ontario in 1963 in a deliberate attempt to determine the feasibility of providing nursing education in a multi-purpose educational institution. The first class of Ryerson nurses graduated in May 1967. We understand that the results of the program are being evaluated by a member of the faculty of the McGill School of Nursing, and the report is expected to be completed in 1970. With the proliferation of various post-secondary institutions in Ontario and elsewhere in Canada it has become feasible to consider developing such nursing programs on a much larger scale.

This has naturally been warmly welcomed by nursing leaders and others who have been inclined to emphasize the desirability of increasing the "educational" content of nursing courses. The principal obstacles to date appear to have been institutional and financial. Because these institutions are multi-purpose they are usually under educational authorities. Thus, jurisdictional disputes can arise and, in particular, the "health authorities versus educational authorities issue" comes

⁹⁴*Ibid.*, p. 2.

up for much discussion. The related issues of centralization versus decentralization of authority for nursing and other types of training also become entangled in the debate. On the latter point, Murray's study clearly indicates why a high degree of centralization of such authority is needed, as does the report of the Saskatchewan Ad Hoc Committee on Nursing Education.⁹⁵

Evidence related to the advantages of putting nursing education under educational rather than health jurisdiction is more difficult to assemble, mainly because there has not yet been time to evaluate the new programs which are being introduced. The provinces which have to date gone furthest in this direction are Saskatchewan and, more recently, Quebec.

The province of Saskatchewan instituted one of the most thorough-going reorganizations of nursing education in the country in April 1966, when responsibility for the education of nurses was transferred from the Department of Health to the Department of Education. The Saskatchewan Nurses Education Act (1966) established a "Board of Nursing Education" consisting of a representative of the Department of Education, a representative of the Department of Public Health, six persons appointed by the Nurses' Association, one by the Saskatchewan Hospital Association, one by the Catholic Hospital Conference of Saskatchewan, one by the Board of Governors of the University of Saskatchewan, one by the Council of the College of Physicians and Surgeons of the province, and one other person appointed by the Minister of Education.⁹⁶ To date, only one central nursing school has actually been established in a multi-purpose educational institute, the Saskatoon Diploma School, which is being operated in conjunction with the Institute of Applied Arts and Science in Saskatoon. A similar school is expected to be established in Regina, but at present the hospital schools are continuing to provide all the nursing education in the southern part of the province.

In Quebec, plans have recently been announced to transfer nursing programs from the hospitals to professional and vocational colleges, the change-over to be completed in 1970. Responsibility for nursing education has been transferred from the Department of Health to the Department of Education. Registered nursing programs will be provided in three-year courses offered by the technical schools with clinical experience being obtained in hospitals. Two-year programs will also be available for students planning to go on to the three-year B.Sc.N. degree at university.⁹⁷

Ontario policies concerning nursing education have in recent years placed considerable emphasis on the "manpower supply" aspects of the problem. The elements of the existing provincial government policy were outlined in a series of papers presented at nursing education conferences held in Ottawa, London and

⁹⁵V. V. Murray, *op. cit.*, Chapter 10.

⁹⁶Statutes of Saskatchewan, *Nurses Education Act*, 1966.

⁹⁷News report, *The Medical Post*, June 3, 1969, p. 3.

Toronto in June 1965.⁹⁸ In his paper, the Minister of Health explained that one of the responsibilities of the OHSC was to "see to it that there are adequate numbers of thoroughly trained personnel to staff the hospitals of our province". He went on to explain the way the working party which he established to look into the question of how such numbers could be produced had arrived at the plan to produce 5,000 diploma school graduates annually by 1970 or 1971. The deliberations of this working party and the difficulties encountered in implementing its plan are discussed in considerable detail in Murray's study.⁹⁹ The Minister explained to his audience of nurses on this occasion that "as I looked at this whole problem of nursing education the question was not only how many nurses should be trained (most of us were still talking about training in those days) but also *how* should nurses be trained? Should they be the responsibility of the educational authorities or should they be the responsibility of the service personnel? Or should it be a combined responsibility?" He recognized that "some of these questions are not yet answered completely to the satisfaction of all". With respect to the length of the program, the Minister indicated that by about 1970 "we believe that all schools of nursing in the Province should be ready to change over to the two-year program". As of September 1975, the uniform course would be two years of educational experience, at the conclusion of which students would write their registration examinations, be entered on an Educational Register while working in a hospital for one year, and thereupon become eligible for full registration.

The regional approach to nursing education was explained at the same meetings by the Commissioner of Hospitals of the OHSC, who provided a succinct definition of a regional school.

The definition of a regional school has been accepted as one which shall have its own governing body which is representative of the agencies providing clinical experience and the community at large and which controls the educational and the clinical resources within a geographic area and is responsible for 1) approving aims, policies and standards; 2) securing finances and approving the budget of the school; 3) securing the interest and support of the public for the school; 4) securing a well-prepared teaching staff . . .¹⁰⁰

The Commissioner explained that the schools would be based on one hospital which supplied the necessary physical and administrative supports, but that each school would be independent of the hospital in determining its academic program and organizing its clinical experience. Each school would prepare its own budget for the direct expenses related to its responsibilities and would control the expenditure of these funds. All necessary capital outlays would be provided by the Province. Students would not be required to live in residence.

⁹⁸Ontario Department of Health, "Proposals for the Future Pattern of Nursing Education in Ontario", 1965, mimeographed.

⁹⁹See V. V. Murray, *op. cit.*, Chapter 10.

¹⁰⁰Ontario Department of Health, *op. cit.*, p. 11.

Nursing leaders in the province apparently accepted the concept of the regional school, partly because of the degree of independence which these institutions formally would seem to have. The editor of the journal, *Canadian Nurse*, (Mus-sallem) condemned "this move toward the establishment of separate, single-purpose institutions under the general jurisdiction of the provincial Department of Health Hopefully", she wrote, "this system eventually will be introduced into the educational stream as an integral part of the province's newly developing, post-high school institutions."¹⁰¹ And the RNAO, at its Annual Meeting in April 1967, declared that ". . . the system of separate, single-purpose institutions under the general jurisdictions of the provincial Department of Health — as exemplified by regional schools of nursing in Ontario — is incompatible with the stated beliefs of the profession".¹⁰² This position was strongly supported by a speaker at the convention, D. McCormack Smyth, Dean of Atkinson College, York University. It was proposed at the same meeting that the diploma schools in the province be integrated with the Colleges of Applied Arts and Technology. The tentative beginnings of such a development might be suggested by the support which York Regional School draws from the Seneca College of Applied Arts and Technology.¹⁰³

With regard to the latter point, it may be of interest to note that the Committee of Presidents of Universities of Ontario recommended in its *Report on Health Sciences in Ontario Universities*, in May 1967, that the universities should have primary responsibility for medical, dental, public health, medical social work, clinical psychology, speech therapy and audiology, and should also provide degree programs for leaders in nursing, pharmacy, physiotherapy, occupational therapy.¹⁰⁴ The same report proposed that responsibility for the training of large numbers of personnel in shorter diploma courses in nursing, pharmacy, physiotherapy, occupational therapy, and dietetics should rest with the Colleges of Applied Arts and Technology and hospital schools. In establishing these priorities, the presidents proposed the development of a coordinating planning council similar to the newly formed Ontario Council of Health in order to eliminate duplication of effort and to provide for close cooperation among the government, universities, hospitals, and the health professions.

The Committee has considered these various views concerning the education of nurses and has reached the conclusion that it would be desirable to encourage the further development of diploma nursing programs in the new institutions of higher learning being developed in this province. We would not propose a sudden closing of the existing hospital and regional schools. But we would encourage the future development to be in multi-purpose educational institutions, such as the Colleges of Applied Arts and Technology. If entrusting the overall administration of the program to the Department of Education might bias the program in the

¹⁰¹*Canadian Nurse*, Vol. 63, No. 4, April 1967, p. 27.

¹⁰²*Canadian Nurse*, Vol. 63, No. 6, June 1967, p. 11.

¹⁰³See Letter to the Editor, *Canadian Nurse*, Vol. 63, No. 11, November 1967, p. 4.

¹⁰⁴Committee of Presidents of the Universities of Ontario, *Report on Health Sciences in Canadian Universities*, Toronto, May 1967, pp. 3-5.

direction of education, entrusting it to the Department of Health could bias it in the direction of training and service. In the light of present and foreseeable public needs and professional attitudes, the former bias, if it is inevitable, is, in our judgment, preferable. In any event, there is no reason to believe that transferring nursing education to multi-purpose educational institutions would justify or require any lengthening of the program or any reduction in the output of nurses. At the same time, it is essential that with such a transfer of jurisdictions the manpower aspects are not neglected. The Coordinating Committee of the Cabinet on Health Education, which we propose in Chapter 24, would seem the logical agency to ensure that these matters are kept in balance and that there is no distortion of needs.

It should also be noted that there is no suggestion here that the nurses educated in multi-purpose institutions would necessarily be identical in their preparation to those educated in the existing service-oriented "hospital schools". It is recognized in the United States that the so-called associate degree nurses trained in the multi-purpose institutions there cannot be expected to administer nursing units or to accept immediately the same kind of work assignments that can be given to nurses with more practical experience behind them.¹⁰⁵

Recommendations:

- 84 That control of diploma level nursing education should pass to the Department of Education with a Nursing Education Advisory Committee being established to review nursing education and to advise on curriculum, length of programs and other relevant matters. Representation on the Nursing Education Advisory Committee should include members from university faculties of nursing, faculties of medicine, hospital associations, the nursing profession, the Department of Health, the Department of Education, and the general public.
- 85 That the expansion of schools of diploma level nursing should take place in the Colleges of Applied Arts and Technology to the extent feasible.
- 86 That at least for some considerable time, the present hospital nursing schools, regional schools of nursing and "special" schools of nursing should continue to operate with such phasing out as seems timely.
- 87 That the financing of new schools of nursing be under the Department of Education, and that financing of hospital, regional and special schools of nursing be removed from the aegis of the Ontario Hospital Services Commission. The Committee is aware that there will be some short-term problems on matters of administration in such a change and recommends that housekeeping functions, such as accounting, and paying of bills, should continue to be carried out by the hospital in which a school of nursing may function. Budgeting and financing, however, should be done

¹⁰⁵W. W. Logan, "Overview of the Associate Degree Nursing in the U.S.A.", *International Journal of Nursing Studies*, August 1967.

through the Department of Education if at all possible; if this is not feasible they should be done through the Department of Health but not through the Ontario Hospital Services Commission.

- 88 That the manpower interests of the Department of Health in educational programs for nurses be recognized, and to this end that manpower aspects of nursing education programs be considered by the proposed Coordinating Committee of the Cabinet on Health Education.
- 89 That prior to new schools of nursing being established, the Nursing Education Advisory Committee ensure that adequate clinical facilities will be available for the students before the school is approved.
- 90 That the use of clinical facilities by the students of nursing should not imply that the student has a service obligation to the institution providing these facilities.
- 91 That the length of training programs for diploma nurses be not longer than two years academic.

University Programs

At present, eight universities in Ontario offer nursing programs. These are of two basic types: "certificate" programs and "degree" programs.

Certificate Courses

The certificate programs are one-year post-R.N. courses offered to registered nurses who qualify for university entrance. These courses provide additional study in the fields of public health, teaching and administration. Despite the shortages of nurses with such additional qualifications, in recent years universities have been abandoning these programs, especially those providing the certificates in education and administration. A number of explanations have been given to account for this paradoxical development: shortages of qualified staff and facilities in university schools of nursing have forced university faculties to choose between maintaining the certificate programs and expanding the degree offerings; nursing educators prefer to develop degree courses because they doubt the value of the certificate programs for the preparation of nursing specialists, and believe that the new Colleges of Applied Arts and Technology would be more suitable than universities as places for the certificate programs to be offered.¹⁰⁶

The Committee recognizes the difficulties being experienced by university faculties in meeting the demand for university-educated nurses and will make recommendations designed to improve the position of the universities in this regard. However, we are not convinced that the Colleges of Applied Arts and Technology are yet in a position to assume the responsibility of providing this

¹⁰⁶V. V. Murray, *op. cit.*, pp. 145-146.

certificate level preparation. At the same time we believe that the certificate programs should be continued in order to help meet the needs of the province for nurses with some specialist qualifications.

Recommendation:

- 92** That post-R.N. certificate programs in public health, teaching, and nursing administration continue to be offered in university schools of nursing.

It is also important that these and other programs to improve the qualifications of nurses be utilized. We believe that steps should be taken to encourage nurses to seek improvements in their qualifications and to update their skills and understanding of nursing practice.

Recommendation:

- 93** That the Province of Ontario ensure that more facilities are available for the continuing education of nurses, and that nurses be encouraged by financial and other incentives to participate in such continuing education programs.

Degree Courses

A variety of baccalaureate programs have been offered by universities in Ontario. Although there is still considerable variation in their structure a basic pattern is now emerging in the form of a four-year "integrated" course in which the student obtains a basic registered nurse's training along with a three-year university course in a single "package". The graduates of these programs are expected to possess more knowledge of the basic sciences underlying nursing functions and a broader general education than the ordinary registered nurse. They are also expected to have a higher level of competence in the specialties of public health, education and administration.

A very small number of nurses are presently trained to the university degree level compared to the volume of R.N. diploma graduates. Because the graduates of the degree programs are a source of teachers, administrators and (we hope in the near future) of clinical specialists, attention is frequently drawn to the ratio between the degree graduates and the basic diploma graduates. The Canadian Nurses' Association has estimated that this ratio should be in the order of 1:3; the RNAO has suggested a ratio of 1:4. The discrepancy is not of much practical importance, however, in view of the fact that the ratio in Ontario is about 1:16 (1967) and only such an enormous expansion of the existing university programs as to be unfeasible could be expected to bring about any substantial change in this ratio in the near future.¹⁰⁷

Although we cannot say what the ideal ratio of degree and non-degree nurses should be, and while substantial improvement over the present ratio is required,

¹⁰⁷Registered Nurses' Association of Ontario, Brief to the Committee on the Healing Arts, 1966, pp. 17-18.

we do not believe that the suggested ratio of 3:1 or 4:1 is realistic in the foreseeable future. The situation is such, however, that strenuous efforts should be made to increase the ratio of degree to diploma nurses and our recommendations regarding the expansion of educational facilities for degree nurses should assist in this effort. (See Recommendation 96.)

It is possible that the existing facilities for the preparation of degree-level nurses could be more effectively utilized. In particular, there may be some inefficiency in university procedures for selecting entrants and shaping their programs of studies. Murray suggests, for example, that some measures could be taken to improve the coordination of the university nursing school programs, notably through the proposed Association of Ontario University Schools of Nursing. Such a body could be expected to undertake a program of gathering information about university nursing education, to formulate plans and priorities, and to act as a spokesman for the university schools when they seek funds from the provincial government. In general it would seek to shape the development of the whole university system of nursing education in the province.¹⁰⁸ The problem with such proposals for developing coordinating institutions of this kind, however, is that the stronger their design, the less acceptable are they likely to be to the universities, which are properly jealous of their autonomy in selecting and educating their students.

Should it be found that the university nursing education facilities are restricting the supply of nurses, not only because of inadequacies in size and efficiency, but also because of a failure to attract sufficient applicants, certain specific recommendations which would alleviate the latter problem also can be made. The University of Toronto School of Nursing has suggested, for example, that the existing scheme of bursaries, scholarships and other financial aid is not adequate.¹⁰⁹ The RNAO has recommended that post-baccalaureate degree candidates in university schools be provided with from \$3,000-\$4,000 of financial assistance,¹¹⁰ and Murray urges that the existing scheme for bursaries, scholarships and other financial aid available to nurses at the degree level be thoroughly re-examined. Murray points out, for example, that trained registered nurses returning for a degree can get assistance from the Department of Health for only two years, while most universities now require three years of study. He also points out that the Department of Health bursary plan does not extend to regular baccalaureate students.¹¹¹

The Committee is particularly impressed by the suggestion that universities should consider expanding the "mature student" policies as they relate to nursing. The University of Toronto School of Nursing faculty has indicated in its appearance

¹⁰⁸V. V. Murray, *op. cit.*, p. 236.

¹⁰⁹University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, p. 656.

¹¹⁰Registered Nurses' Association of Ontario, Brief to the Committee on the Healing Arts, 1966.

¹¹¹V. V. Murray, *op. cit.*, pp. 240-241.

before the Committee that the experience with those admitted under the mature student provision has been generally satisfactory and that students have not been found to be particularly handicapped.¹¹²

Recommendations:

- 94 That nursing schools encourage diploma nurses who may be able to take advantage of mature student requirements of the universities and who have the appropriate potential and interest to undertake degree programs in nursing.
- 95 That for registered nurses authorized by law to practise nursing and demonstrating a standard of excellence in practice, the opportunity to obtain higher professional educational qualifications ought not to be foreclosed by reason of a failure to take any part of a fifth year of a five-year stream in the Ontario high school system.

Useful as such specific proposals are for improving the operation of the university schools of nursing, they must not be allowed to obscure the important fact that at the university level, as Murray puts it, "the basic prerequisite to the enlargement of baccalaureate degree programs is the immediate increase in faculty sizes and increased budgets to permit the reduction of teaching loads, the financing of research, the launching of graduate programs, and the attraction of high calibre senior faculty"¹¹³ The School of Nursing at the University of Western Ontario recommended to the Committee "that a study be undertaken to determine the number of registered nurses qualified for entrance and likely to seek admission to post-RN Baccalaureate programs in Ontario universities within the next ten years, the number of these programs needed and where best to locate them"; "that teaching fellowships be set up in graduate education programs in nursing"; and "that there be greatly expanded efforts and resources to encourage qualified Canadian nurses to seek preparation at the doctoral level, and to attract them to leadership positions in nursing in Canada, and to utilize to the optimum their potential contribution in these positions."¹¹⁴ Similarly the University of Toronto School of Nursing has urged that "the university schools of nursing in Ontario expand, and if necessary, new schools be established, so that two categories of nurses (university and diploma) can be prepared in the ratio of 1:3"; "that a graduate degree program in nursing be established in an Ontario university"; that "present university schools of nursing expand their facilities to enrol a greater number of students in the basic course"; "that new schools of nursing be established in other universities to increase the number of graduates with Baccalaureate degrees"; "that post-Baccalaureate degree courses be developed by a number of university schools and that financial assistance in the amount of \$3,000-\$4,000 be

¹¹²University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, p. 62.

¹¹³V. V. Murray, *op. cit.*, p. 240.

¹¹⁴See University of Western Ontario School of Nursing, Brief to the Committee on the Healing Arts, 1966, p. 17.

available to assist nurses toward obtaining these degrees"; and "that graduates from diploma courses who are now working have the opportunity to obtain credits towards a degree, and that this program be continued until a sufficient ratio of degree and diploma graduates is attained".¹¹⁵ At this time the only graduate program in nursing in Ontario is offered at the University of Western Ontario, where it was established in 1959. It is a program of two academic years in length leading to an M.Sc.N. For the first seven years, the program prepared administrators in nursing. Commencing in the fall of 1966, a second program designed to prepare nursing teachers became available. Enrolment in 1967-1968 was twelve; by 1970-1971 the school anticipates an enrolment of twenty-five.¹¹⁶

The Committee concurs with the view that immediate action should be taken to expand the capacity of the university schools of nursing.

Recommendation:

- 96** That the Government of Ontario take such measures as are necessary to increase enrolment in university degree programs in nursing. Such measures should include (a) appropriate salary levels for teachers in all nursing programs in order to attract adequate numbers of applicants with appropriate qualifications to undertake degree courses; (b) enlargement of facilities at present university schools of nursing to accommodate an increased number of nursing students; and (c) expansion of programs of graduate studies in nursing and appropriate expansion of facilities to supply more teachers with adequate financial support to assist graduate students and with opportunities and support for nursing research by faculty members; the foregoing is based on the belief that in the future, nursing teachers in diploma schools of nursing should have a university degree and that nursing teachers in the university schools of nursing should have training beyond the Bachelor of Science of Nursing, although the Committee recognizes that this will not be possible in the immediate future.

Education of Other Nursing Personnel

Registered Nursing Assistants

Registered nursing assistant training programs are provided by hospitals and high schools, and by the Ontario Department of Health. There are sixty training centres in all (January 1970), distributed throughout the province. The training period was reduced in 1967 from forty weeks to thirty-six weeks. This is divided between classroom work and hospital experience. Admission standards have been raised since the occupation was created in 1947 and now require grade ten from

¹¹⁵See University of Toronto School of Nursing, Brief to the Committee on the Healing Arts, 1966, p. 4.

¹¹⁶University of Western Ontario School of Nursing, reply to Questionnaire "C", Committee on the Healing Arts.

either of the high school streams. Instructors in these programs generally have R.N. diplomas, although the Nurses Act requires this only of the director of registered nursing assistant training centres.

In marked contrast to the controversies which surround the education of registered nurses, there appears to be little interest in changing the existing pattern of training for registered nursing assistants. As we noted earlier, however, there has been some suggestion that this category should be dissolved, with the more able registered nursing assistants being upgraded to registered nurse status and others reduced to the status of ward aides or assistants. The University of Toronto School of Nursing has suggested, for example, that while the general experience with the registered nursing assistants in hospitals has been good, there is a tendency for them to be used to perform duties which take them beyond their training. As one spokesman put it, "the Registered Nursing Assistant category was invented at a time when it was thought that the personal care of the patient was probably the simplest care that could be given . . . , whereas now with a fuller understanding of the psychological factors involved in illness, this is no longer thought to be so."¹¹⁷ Nevertheless, the demand for this class of workers appears to be growing rapidly at present.

The Committee agrees that there is a continuing role for registered nursing assistants to play in the health services system.¹¹⁸ The general experience with the work of this group appears to have been highly satisfactory. Therefore, the Committee does not see any good reason to alter the training program in any important way, or to increase its duration.

Recommendations:

- 97** That the length of registered nursing assistant training programs be not longer than thirty-six weeks.
- 98** That for the time being, the educational programs for registered nursing assistants remain the responsibility of the Department of Health.

Practical Nurses and Orderlies

Preparation of so-called "practical nurses" and of aides and orderlies is left almost entirely to the hospitals and other employing agencies. Most of these provide some form of in-service training programs, some of which may be quite formal in design, others nothing more than a short period of familiarization with the work provided by observing those already doing it. There are no general standards for such programs or for admission to them. Although the Committee is aware of the great importance of orderlies and nursing aides in the operation of hospitals and other health care institutions, the kind of work they are called upon to do probably does not require a more formal kind of education program than that being provided at

¹¹⁷University of Toronto School of Nursing, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, pp. 597-598.

¹¹⁸See p. 168.

the present time. In view of the very large numbers of aides, orderlies and "other hospital nursing personnel" now being required,¹¹⁹ it would seem desirable to impose as few formal educational requirements as possible upon those who might be attracted to these employments.

Regulation of Nursing

It has already been shown in the description of nursing practice that nurses are subject, at least in their principal employments, to much supervision and control by the physicians and administrators under whom they do their work. Reference has been made, for example, to the process whereby the nature of medical procedures which may be performed by registered nurses in hospitals is determined by physicians, and by hospital authorities who are responsible for establishing the procedures and rules which govern such activities of nurses in each particular hospital.¹²⁰ In this section, other forms of regulation of the practice of nursing will be considered. The most important of these are the legal and professional controls which regulate the qualifications of certain classes of nurse practitioners.

It was noted earlier that no group in Ontario has a monopoly on the giving of nursing care for hire. There are no licensing or other provisions to restrict the application of the term "nurse" to persons with some minimum of training or experience. Only the terms "registered nurse" and "registered nursing assistant" are restricted by law to persons able to meet the requirements for registration as administered by the College of Nurses of Ontario. The College, and the RNAO would, however, favour implementation of a licensing procedure which would similarly restrict use of the term "nurse". As the College has put it, "the profession believes that safe nursing care can be assured only if there is legislation providing for the establishment of standards of nursing education and practice and the licensing of all who nurse the sick for hire"; and further, "the profession believes that only in this way can the public know that all those who offer to render nursing service are in fact qualified to do so".¹²¹ It is recognized, however, that at present it is impossible to define the practice of nursing so closely as to restrict the types of work done in it to those who possess the necessary qualifications.

Recommendation:

99 That there should be no overall licensing of those who nurse for hire.

Under the existing arrangements the employers of nurses must themselves judge whether they require the services of trained nursing personnel or whether untrained workers will meet their needs. Most of these employing agencies, including the hospitals, do hire large numbers of untrained aides and orderlies, as well as many trained but not registered graduate nurses, to meet their overall nursing staff requirements. Other employers, especially nursing homes and private

¹¹⁹See Chapter 6, Table 6.3.

¹²⁰See p. 156.

¹²¹College of Nurses of Ontario, Brief to the Committee on the Healing Arts, 1966, p. 1.

duty employers may rely almost entirely upon untrained workers to meet their needs. It was noted earlier that some of these employers are required to include some proportion of registered nurses in their staffs if they are subject to the provisions made in the Homes for the Aged Act, the Charitable Institutions Act, and the Nursing Homes Act 1966.

While the untrained personnel referred to above are not subject to any centrally administered requirements concerning their qualifications to engage in nursing activities, the individual employers of such workers may themselves impose such requirements. Usually, for example, these employers will require grade eight education or better, and sometimes successful completion of an in-service training program which they themselves provide. Some hospitals provide substantial training programs for orderlies, sometimes up to the standards of registered nursing assistant's training; but there is a conspicuous lack of uniformity in these practices.¹²²

To the extent that employers judge that they do require the services of registered nurses or registered nursing assistants, they provide the market for workers who meet the requirements for such designations as laid down by the Nurses Act and its regulations, and administered and interpreted by the College of Nurses of Ontario. The effect of these regulations is to require that the applicant graduate from an Ontario school of nursing approved by the College, pass an examination designated by the College, and pay the required annual registration fee. If the applicant is trained outside Ontario, her training is evaluated by a committee of the College, and if it is deemed satisfactory, she is registered. If there is a deficiency in the applicant's training, she may be required to write some part or all of the Ontario registered nurse's examination or take a further course of training before being registered.¹²³

The Committee is conscious of the problems which these registration procedures create for nurses moving from one country to another and for the regulatory bodies faced with the task of assessing the nurses' qualifications. There is a danger that requirements may become overly rigid and formal. The Committee notes in this regard the recent salutary developments whereby the College of Nurses relaxed some of its regulations requiring foreign-trained nurses to take additional courses before being allowed to write examinations in a subject.

Recommendation:

- 100** That organized bodies of nursing in Ontario take the initiative with their counterparts throughout Canada to encourage the International Council of Nurses to develop world-wide agreement on qualifications for practice in order to facilitate the international mobility of nurses.

¹²²V. V. Murray, *op. cit.*, p. 124.

¹²³*Ibid.*, p. 123.

The discipline of registered nurses also is entrusted to the College of Nurses. The College is empowered to suspend or to revoke a nurse's certificate of registration. In practice, the Discipline Committee of the College of Nurses does not seek out misdemeanours, but only deals with those reported to it.¹²⁴

While we have found the regulation of registered nurses by the College to be generally effective, and we believe that they should continue to be self-regulating, the Committee believes that for the reasons discussed in Chapter 25, lay representation should be provided on the Board of all professional regulatory bodies.¹²⁵

Recommendation:

- 101** That the College of Nurses of Ontario remain the certifying and regulatory body for registered nurses in Ontario, but that there be representation from the Department of Health and significant lay representation on the Board of the College.

While we recognize the historical reasons for placing registered nursing assistants under the aegis of the College of Nurses, we also feel that the responsibilities of the College of Nurses for regulating registered nursing assistants are not appropriate. The Committee concurs with the principle, enunciated in the *Report of the Royal Commission Inquiry into Civil Rights*, that one occupational group should not be empowered to regulate another group.¹²⁶

Recommendation:

- 102** That responsibility for the certification and discipline of registered nursing assistants be removed from the College of Nurses and assigned to the proposed Health Disciplines Regulation Board through a Division for registered nursing assistants.¹²⁷

The Committee notes that the College of Nurses is also empowered by the Nurses Act to prescribe "the standards for the approval of nursing registries" — that is, agencies which offer to supply nursing services to the public and to find work for those who would be so employed. The College has not exercised this power, however, for it claims to be unable to "cope with the problem until standards have first been established for the licensure of all who nurse for hire".¹²⁸ Thus, it would seem that the main weakness in the system of regulation of the practice of nursing lies in the area of those private employments where those who work as nurses are least likely to be subject to the supervision of physicians and other qualified health practitioners, and where the influence of the nursing organizations, both the College and the voluntary RNAO, is least likely to be felt. While the Committee recognizes that this is a potentially dangerous situation, we

¹²⁴College of Nurses of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, February 21, 1967, pp. 529, 534.

¹²⁵See Recommendation 315, Chapter 25.

¹²⁶Province of Ontario, *Report of the Royal Commission Inquiry into Civil Rights*, Report No. 1, Queen's Printer, Toronto, 1968, Vol. 3, p. 1205.

¹²⁷See Chapter 25.

¹²⁸College of Nurses of Ontario, Brief to the Committee on the Healing Arts, 1966, p. 6.

have received no evidence of harm being done by nurses or by unqualified persons providing nursing services to the public in these situations. If the expanded program of research concerning nursing practice provides a greater understanding of the capabilities and limitations of various grades of nursing personnel, it may eventually become feasible to establish more specific forms of regulation in this regard.

In the case of the new clinical specialties for diploma nurses, which we have recommended be established and promoted, we have suggested that the College of Nurses should maintain special registers on which nurses possessing these special areas of competence would be entered.

Psychiatric Nursing

Nursing Personnel in Psychiatric Institutions

The nursing staff forms the largest category of personnel employed in inpatient psychiatric facilities in Ontario with a total of 9,545 persons or 54.7 per cent of all personnel in these institutions (excluding psychiatric units in general hospitals). However, as may be seen from Table 10.3, of the 9,111 full-time nursing staff, a large number are without formal nursing qualifications. Others are qualified nurses with little psychiatric training, or unregistered psychiatric nurses who have received their training outside Ontario.

All these different categories of nursing staff are generally referred to as "psychiatric nurses", a term which denotes the work setting rather than the particular qualifications of the nurses.

Functions

Some nursing functions in a psychiatric setting are basically identical with those on a non-psychiatric ward. The nurse is in charge of the supervision and provision

TABLE 10.3

Full-time Nursing Staff in Inpatient Psychiatric Institutions, Ontario, 1967¹

Category	Number
Psychiatric nurses	157
Registered nurses	1,257
Graduate nurses, not registered	169
Student nurses	528
Registered nursing assistants	1,972
Nursing assistant trainees	586
Other nursing personnel	4,442
Total	9,111

¹Excluding psychiatric units in general hospitals.

of general care to the patient; she dispenses drugs used in treatment, performs routine medical checks and makes reports of her observations on the patient's progress. Very often, however, the content of these functions and the specific knowledge needed to perform them are different. On a psychiatric ward, for example, routine medical checks may be the same or they may be minimized, depending on whether a patient is receiving physical or psychotherapeutic treatment. Similarly, drugs used in the treatment of a schizophrenic patient would require specific knowledge of their application and effects.

The functions which do not overlap are those connected with the socially and psychologically therapeutic roles of the nurse in milieu therapy, a method of treatment which is being increasingly emphasized in psychiatric settings. Either the nurse may function as part of a team working to create the desired social environment and opportunities for worthwhile activities on the ward for all the patients, or she may be assigned to specific patients for whose needs she is individually responsible. When the latter pattern is utilized, the nurse may be expected to engage in the formation of a one-to-one psychologically supportive relationship with the individual patients in her care. In both patterns, the nurse also makes regular and uninterpreted reports of her observations of the spontaneous relationships of patients on the ward from which considerable information of great diagnostic significance can be obtained.

In the modern psychiatric inpatient unit, these social and psychological functions are the most important ones, although they do not supplant the other traditional, overlapping functions. While some training in the psycho-social care of patients would appear mandatory for all nurses, the psychiatric nurse needs a special orientation and training so that she will have sufficient self-knowledge to be able to grasp and evaluate her own psychological responses to the patients in her care.

Training

The only category of nurses who have been specially trained to carry out these functions are those who have received their training in the four western provinces of British Columbia, Alberta, Saskatchewan and Manitoba, in Great Britain or in Jamaica, where separate training programs for psychiatric nurses are offered. Most of these nurses, however, are unable to achieve registration status in Ontario because they do not have sufficient medical background in such fields as paediatrics and obstetrics to satisfy Ontario requirements. Because their credentials are not recognized, they are denied the same status and financial reward which are accorded to registered members of the profession. They are also restricted in their educational and professional advancement. As a result, very few graduates of these psychiatric nursing programs have been attracted to work in the province.

Recommendation:

103 That nurses trained outside Ontario as psychiatric nurses in institutions which meet the educational standards and quality of instruction

satisfactory to the College of Nurses should be registered by the College of Nurses on a special register as certification of competence in psychiatric nursing. Though nurses registered in such a way would not be fully qualified registered nurses, they should be given status and pay equal to those of registered nurses when working in a psychiatric setting.

With the exception of those who have been trained in psychiatric hospital schools of nursing, registered nurses trained in Ontario have received only limited psychiatric training. The Nurses Act of Ontario does not specify any minimum training in psychiatric nursing for approved programs, although the majority of schools provide their students with at least three months' clinical experience in a psychiatric hospital or a psychiatric unit of a general hospital. This short training period is far from adequate. It gives the nurse only a general impression of the exigencies of caring for psychiatric patients and provides little more than a background for an informal or formal in-service training program designed to prepare her for work in the psychiatric hospital.

The in-service training which a nurse gets depends very much upon the hospital. The duration of the orientation may last from one day to one week; the facilities for education vary tremendously — from none at all to structured programs of seminars, lectures and case discussions. The benefits the nurse gets from discussions with psychiatrists and staff conferences are limited and the value of lectures given periodically by psychologists or social workers to the nursing staff depends upon the availability of personnel and their willingness to participate meaningfully in such programs.

Nurses who have graduated from schools of nursing in psychiatric hospitals receive more exposure to the field of psychiatry. At present general nursing programs are being offered by three psychiatric hospitals in Ontario, located in Brockville, Kingston and Whitby. These schools provide an invaluable supply of psychiatric nursing manpower but the number of nurses produced has been limited, the three hospital schools having graduated only sixty-nine nurses in 1967.¹²⁹ The Committee believes that even with the establishment of special training programs for psychiatric nurses, Ontario requires more general nurses with greater knowledge in psychiatry. Charles Hanly, in his study *Mental Health in Ontario*, has pointed out that:

Medical authorities are becoming increasingly concerned that nurses on surgical, obstetrical, paediatric and other wards are failing to meet the challenge presented by the special psycho-social patient needs that may arise with hospitalization and treatment.¹³⁰

A psycho-social orientation is needed, not only for the nurse working in a psychiatric setting, but also for other nursing functions in every kind of hospital and clinical setting.

¹²⁹DBS, *Mental Health Statistics, 1967*, Vol. III, Queen's Printer, Ottawa, 1969, Table 13. Toronto, 1970, p. 144.

¹³⁰C. Hanly, *Mental Health in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 144.

Recommendation:

104 That opportunities be made available at some of the nursing schools for student nurses to specialize in psychiatry and to devote a greater part of their practical experience during their undergraduate program to psychiatric nursing. Such programs would, however, lead to full certification as a registered nurse as the student nurse would still be required to fulfil all the requirements for a registered nurse but would have specialized knowledge in psychiatry. Ontario Hospitals and the psychiatric units of general hospitals should be made available for the clinical aspects of such programs.

The need for introducing suitable training programs in psychiatric nursing has already been recognized in Ontario. The first formal training course was started in September 1968. This is a fifteen-week course offered at Ryerson Polytechnical Institute for graduate nurses who are eligible for registration in Ontario or in the jurisdiction from which they come.¹³¹ The University of Toronto School of Nursing and the Clarke Institute of Psychiatry have also agreed to establish courses to produce teachers of nursing who will be responsible for teaching psychiatric nursing in diploma schools.¹³² However, it is evident that with a total of some 25,000 treatment beds in the province's forty-four public and private psychiatric institutions and thirty-eight psychiatric units in general hospitals,¹³³ we need training programs organized on a province-wide basis which will produce graduates on a much larger scale. We have already recommended the development of clinical specialties in nursing for diploma level nurses (see Recommendation 71). We believe that a specialty in psychiatric nursing should be developed as soon as possible. Such a development will concur with recent trends towards the phasing-out of separate programs for psychiatric nurses in the four western provinces of British Columbia, Alberta, Manitoba and Saskatchewan. This concept was recommended by the Royal Commission on Health Services in 1964,¹³⁴ and steps have already been taken by these four provinces to implement the Royal Commission's proposal that special programs be set up to enable qualified psychiatric nurses to qualify as registered nurses.¹³⁵

Recommendation:

105 That psychiatric nursing be recognized as a clinical specialty in nursing and that postgraduate programs be established for diploma nurses to specialize in this field as well as specialty programs at the Master's degree level for degree nurses to provide the teaching and research nursing personnel required in this field.

¹³¹Ryerson Polytechnical Institute, *Psychiatric Nursing Program*, 1968 (brochure).

¹³²C. Hanly, *op. cit.*, p. 149.

¹³³See Chapter 28, Table 28.1.

¹³⁴*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, pp. 63-64.

¹³⁵Editorial, *The Canadian Nurse*, October 1967, p. 25.

The Committee believes that the two proposals for including more basic psychiatric concepts into the general nursing curriculum and for developing and giving formal recognition to psychiatric nursing as a clinical specialty will, in the long run, attract more qualified nurses to enter and stay in the psychiatric field. On the other hand, the Committee is aware of the problems which will be involved in the implementation of these recommendations. A considerable length of time will elapse before more psychiatric courses can be developed and accommodated in the basic nursing curriculum. The additional training that will be required of qualified nurses to work in a psychiatric setting will make initial recruitment difficult.

The Committee is therefore doubtful whether reliance on postgraduate programs alone would provide psychiatric settings with an adequate supply of highly trained psychiatric nurses in the immediate future. The Committee is convinced that the overall shortage of mental health workers in Ontario is so acute that experiments should be undertaken along other avenues which may produce adequately trained psychiatric nurses in a shorter time.

Recommendation:

- 106** That the Department of Education should consider the development of a pilot project for a two-year program in psychiatric nursing, similar to those offered in England and Alberta. Graduates from such a program would be certified as psychiatric nurses on the special register of the College of Nurses. Opportunities should be available to such nurses to continue their education, and with approximately one further year's training in general nursing they should be eligible for qualification as a registered nurse.

Summary and Conclusions

The health workers discussed in this chapter constitute the largest and most diverse group of employees in the health industry. We have seen how difficult it is to generalize about them. The various categories of "nurses" range from the untrained ward aides employed in hospitals, through the diploma-school prepared registered nurses, to university-educated specialists in public health, teaching and administration.

The "practice" of nursing with which these diverse workers are engaged itself has never been unambiguously defined. Even the more restricted "professional" practice of nursing seems to be defined more by the formal limitations on entry to it than by any clear understanding of the duties and responsibilities it entails. Consequently, no one today can say with certainty that "*this* is nursing, *that* is not". Even so, we have been able to see that in general terms "nursing" has been moving steadily away from being a charitable, service-oriented "vocation" towards becoming a "professional" career—a career requiring more and more formal education, "registration" of formally qualified practitioners, and a large measure of self-control by the profession over the education and discipline of members. But nursing has differed in several important ways from other occupations whose

members have sought such trappings of professional status. In their work, nurses have remained subservient to another professional group — the physicians. Nearly all nurses are salaried employees, not independent practitioners. And, being an almost entirely female occupation, nursing has not had the status it might otherwise have enjoyed.

With this background, a number of conflicts which arise within nursing, and among nurses and other groups, can more easily be understood.

The dichotomy between the ideals suited to a vocation dedicated to obedient service and those appropriate to a modern career as a professionally qualified member of the "health team" is one source of the conflicts faced by nurses, and also by those with whom they work today. This particular problem is strongly reflected in the matter of collective bargaining for nurses, a subject which we have considered at some length in this chapter. Similar conflicts of principles and interests have also been encountered in connection with nursing education, with the "manpower" aspects of nursing, and in regard to the appropriate forms of regulation for nursing.

The Committee has examined these problems sympathetically and, despite the paucity of available information concerning the practice of nursing in Ontario today, we have been able to make a number of recommendations to alleviate some of the difficulties which confront nurses and those who use their services. Although our attention in this chapter has been focused on these problems, it should not be inferred that we find nothing "right" about the practice as it exists. On the contrary, we believe that the practice of nursing is in a healthy condition and that the province is, in general, well served by adequate numbers of well-prepared registered nurses, graduate nurses and registered nursing assistants.

The Committee does believe that to preserve this favourable condition, and to improve the practice of nursing further in the future, certain specific steps should be taken at this time. Let us briefly recapitulate them here. First, the Committee is convinced that many of the problems associated with the practice of nursing today arise from a lack of knowledge concerning the nature and proper limits of the practice. When nurses are employed at tasks beneath or beyond what their experience and education has prepared them for, this causes inefficiency in the use made of our available nursing resources. It also causes unnecessary friction between nurses and other groups with whom they work, and some dissatisfaction and lowering of morale within the nursing occupations themselves. We have therefore recommended that, as part of larger studies of the roles and relationships of the health disciplines, the Department of Health and the Ontario Council of Health undertake a continuing review of the work done by nurses and nursing assistants in order to determine ways of effecting a better matching of the capabilities and the duties of nurses. We have also recommended the recognition and further development of clinical specialties in nursing, which we believe will improve both quality and efficiency in nursing practice while at the same time pro-

viding nurses with more opportunity for professional advancement. And we have recommended that nurses should be given more opportunity to participate in making decisions which affect their role. We believe that these steps will help clarify the role of nurses. They should also make nursing a more attractive occupation.

Whether or not the existing and foreseeable number of nurses in the province is "adequate" to our needs has been shown to be a much more difficult question than might have been expected. Not only does it involve difficult judgments concerning "needs", but it calls for more data relating to the supply of nursing services than we found to be available. With regard to the latter, we found that a number of agencies were engaged in collecting and analyzing data relating to the "manpower" aspects of nursing. Yet there has been little effort to coordinate this work and to make use of it for purposes of rationalizing the educational processes, employment practices, and the utilization of available nursing resources. We have recommended, therefore, that nursing manpower planning be centralized in the Ontario Council of Health and the Research and Planning Branch of the Department of Health; and, further, that specific measures be taken to make more use of the non-employed nurses whom we believe to be available in the province. We have suggested that the Ontario Council of Health, the Department of Health, and the planning division of the Ontario Hospital Services Commission should all concern themselves with the latter task.

The Committee is aware that these are long-term measures which cannot show immediate results. Our investigation has led us to believe, however, that a number of things can be done to improve the efficiency with which the nursing needs of this province can be met in the immediate future. One would be to keep our existing nursing schools fully utilized by attracting more students to our existing diploma schools. We have proposed that salaries and working conditions for nurses should be improved, that nurses should be given more opportunity to participate on hospital committees and other bodies affecting their status and role, that new arrangements should be made to facilitate collective bargaining between nurses and their employers, and that the Department of Health and the Ontario Hospital Services Commission should take an initiative in improving the conditions of employment for nurses. All these measures would, we believe, serve to make nursing a more attractive career for young women completing their high school education.

We expect that improving the lot of nurses can go a long way towards increasing the number of applicants seeking admission to the existing diploma schools for nursing education.

Coordinating admissions to these schools through the central clearing house facilities we have recommended should also eliminate some wastage of potential entrants to the profession at this point. The education offered in these schools has also been considered by the Committee. We have had to ask whether this education is appropriate to the needs of nurses, their employers and the community they serve. Our findings may be briefly summarized: we accept the view

that nursing education should go beyond simple "training" in the practical skills of nursing and that it should constitute a form of "higher education" beyond the high school level. We also believe that there should be a large degree of uniformity in this education with no sharp differences in curriculum, faculty qualifications, quality of clinical experience, and length of course among the various diploma schools. This has led us to recommend that control over nursing education in the province should be made a responsibility of the provincial Department of Education, assisted in this work by a Nursing Education Advisory Committee representing the groups affected by nursing education policies. Thus we propose that in the future, nursing diploma education should be provided in the Colleges of Applied Arts and Technology to the extent that they are able to accommodate such programs; that existing hospital, regional and "special" schools of nursing should be phased out as seems timely; and that the financing of diploma nursing education should be done through the Department of Education rather than through the Ontario Hospital Services Commission.

If nursing education is placed in an "educational" setting, we believe that it will be made more attractive to prospective entrants to nursing careers and more adaptable to the changes taking place in nursing practice. By ensuring more effective participation by the users of nursing services in the central policy-making body, we believe that the "manpower" interests of these bodies in nursing education can be protected.

We have not attempted to make detailed recommendations concerning the curriculum of diploma nursing schools or the appropriate form of instruction and experience provided in these programs. We have recommended, however, that before new schools of nursing are established, the Nursing Education Advisory Committee should make sure that adequate clinical facilities will be available. We also recommend in this regard that nursing students should not be expected to provide services in return for the use of such clinical facilities.

Our principal recommendation bearing upon the offerings of the nursing diploma schools is that they develop and make available instruction in clinical specialties for diploma-level nurses. We believe that such a step not only would satisfy the expanding demand of employing agencies for nurses with some specialist qualifications, but also would provide nurses with greater opportunities for advancement in their careers, and the public with an improved quality of nursing care.

We have also noted the possibility that the expansion of rehabilitative, convalescent, and chronic care services in the province may create a demand for nurses specially prepared for these kinds of work. We have recommended that short-term training courses for registered nurses and registered nursing assistants should be provided by the Department of Health as required.

The quality of instruction available in existing nursing diploma schools has been one of the things we have not been equipped to appraise. However, we note that some diploma schools appear to be relying upon faculty with lower quali-

cations than they and the professional nursing organizations deem appropriate. The Committee believes that teachers in diploma schools should have a university degree and recognizes that there is at present a serious shortage of nurses with such qualifications. We have therefore recommended an expansion of university schools of nursing at all levels. We perceive an urgent need for this, to increase the supply not only of teachers of nursing, but of all kinds of nurses with specialist qualifications at the certificate, baccalaureate and graduate levels. We believe that the latter are required in order to provide teachers in the university schools of nursing themselves.

The Committee agrees that much could be done to increase the number of registered and other graduate nurses seeking to improve their qualifications. We have recommended that employers encourage nurses to participate in continuing education programs, that diploma schools encourage diploma nurses to go on to university degree programs, and that universities should not bar mature, experienced nurses from admittance to degree programs because they lack a five-year high school admittance qualification.

The Committee has studied the existing practices governing the regulation of registered nurses and has heard no evidence to suggest that serious problems have arisen under it. Because of our belief in the desirability of increasing public participation in the management of the health professions generally, we have recommended that the College of Nurses of Ontario continue to be the regulatory body for registered nurses but that public representation be added to the Board of the College of Nurses.

The Committee considered carefully the suggestions received concerning the desirability of licensing all who nurse for hire in the province, but we have concluded that such a requirement is not feasible at this time.

In the case of registered nursing assistants, the Committee has recommended that responsibility for establishing standards for the practices of this group be removed from the College of Nurses of Ontario and assigned to the proposed Health Disciplines Regulation Board in accordance with the principles stated in Chapter 25 in our Report.

Chapter 11 Pharmacy

The "drug revolution" clearly has been one of the most significant recent advances in medicine.¹ The adequacy of controls over the provision of drugs to patients has become increasingly important. This chapter deals primarily with pharmacists, the main body of persons dispensing drugs. It is concerned also with supporting personnel and with pharmacies.

The pharmacist plays a number of roles. First, his responsibility for the dispensing of prescribed drugs means that he must see that patients receive the drugs that are prescribed in their appropriate form and in a proper condition; he must also see that all the conditions for dispensing drugs, including special conditions such as those pertaining to the sale of narcotics — the latter, incidentally, not being permitted to all pharmacists — are met properly. Second, he is responsible for the sale of non-prescribed drugs, and certain other substances such as poisons, some of which can be sold only under restricted conditions. Third, those pharmacists who manage pharmacies are businessmen and must cope with the consequent problems.

With the great increases in the number and uses of drugs and in their potency, and with the changes in the form in which they come from the manufacturer, the role of the pharmacist has changed and continues to change. There are differences of view about the pharmacist's future role. Because of the increasing importance of drug therapy, it is most important that this role be clarified.

History

Historically, because of their dual functions both as compounders of chemical substances and as merchants, pharmacists were regarded as being engaged principally in retail trade, and thus did not emerge as recognized "professionals" requiring a licence to practise quite as early as physicians and dentists did. However, the possible dangers to patients arising from the practice of pharmacy by unqualified personnel was the major consideration which led to the passing of the first Ontario Pharmacy Act in 1871.² This Act established the Ontario College of Pharmacy and provided for the registration and licensing of pharmacists.

Beginning with the first Pharmacy Act, which incorporated the Poisons Act of 1859, every subsequent Pharmacy Act has dealt with both the qualifications

¹See, for example, J. W. Grove, *Organized Medicine in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, p. 3.

²S.O. 1870-71, c. 34.

required for registration and the conditions of sale of certain drugs and poisons. The Pharmacy Act has been amended and re-enacted several times over the years, broadening the College's disciplinary powers, changing the procedures for election of the Council, and making provisions for the corporate practice of pharmacy.

Under its statutory power, the College established a teaching institute in Toronto in 1882. Informal affiliation of the College with the University of Toronto began in 1892, and licentiates of the College who so desired might receive the degree of Bachelor of Pharmacy (Phm.B.) upon passing university examinations. In 1927 a two-year academic course was instituted by the College of Pharmacy, a portion of the work being taught in the University of Toronto and replacing the former arrangement of a course of lectures over one year, which had been in effect since 1889. A three-year program was proposed in 1939; but after prolonged negotiations between the College and the University of Toronto, a four-year course commenced in 1948, leading to the degree of Bachelor of Science in Pharmacy (B.Sc.Pharm.) given by the university. The two-year course was continued only for a sufficient time to provide for those who had commenced their apprenticeship before January 1, 1948, and the last class was graduated with the degree of Bachelor of Pharmacy in 1954.

It was not until 1953 that the teaching functions of the College of Pharmacy were transferred to the University of Toronto, which then formally established a Faculty of Pharmacy. The present educational and regulatory arrangements under the Pharmacy Act³ will be discussed in detail below.

The apprenticeship period has also changed from time to time. An apprenticeship period of four years was established in 1889. It was reduced to three years in 1927 and two years in 1944. New arrangements for apprentices were established, and the apprenticeship period was reduced from two years to eighteen months in 1954, and then to twelve months in 1963. In 1964 a further amendment allowed graduate pharmacists to complete their apprenticeship as "internes", and to dispense prescription drugs without supervision.⁴

An amendment also was made in 1964 which permitted the College to develop regulations regarding the space, equipment and facilities of a pharmacy.⁵ The first regulations under this provision came into effect on January 2, 1967.⁶

Manpower

The adequacy of the supply of pharmaceutical services depends primarily on the total number of pharmacists, their distribution by area and by type of practice, the number and distribution of pharmacies, and the proportion of the pharmacists' time spent on non-professional activities.

³R.S.O. 1960, c. 295.

⁴S.O. 1964, c. 89, s. 8.

⁵S.O. 1964, c. 89, s. 6.

⁶O. Reg. 386/66.

Table 11.1 shows the sources of pharmaceutical manpower for the years 1956-1968, and Table 11.2 shows the total number of registrants at various times from 1955 to 1968. During the period from January 1956 to January 1968, 1,282 registered pharmacists were added to the Register, including a number of previously unregistered pharmacists working in fields where a licence was not required, while 400 names were removed from the Register. The supply of

TABLE 11.1
Numbers of Registrants in the Ontario College of Pharmacy, 1956-1968

Year	Graduates, University of Toronto	Other jurisdictions	Total
1956	46	35	81
1957	45	37	82
1958	80	29	109
1959	69	29	98
1960	92	8	100
1961	72	13	85
1962	73	15	88
1963	117	12	129
1964	76	22	98
1965	89	12	101
1966	79	35	114
1967	68	35	103
1968	86	74	160
Total	992	356	1,348

SOURCE: Ontario College of Pharmacy, Brief to the Committee on the Healing Arts, 1966, p. 37. Figures for 1967 and 1968 received directly from Ontario College of Pharmacy.

TABLE 11.2
**Number of Licensed Pharmacists on the Register of the Ontario
College of Pharmacy, Various Dates, 1955-1968**

Date	Number of pharmacists on the Register ¹
September 1955	3,511
May 1957	3,730
May 1958	3,728
May 1960	3,828
November 1962	4,063
November 1963	4,100
November 1964	4,271
November 1965	4,303
November 1966	4,347
November 1967	4,393
November 1968	4,461

¹These figures include pharmacists who have retired, reside outside the province, or have other employment.

SOURCE: Ontario College of Pharmacy.

pharmacists from other jurisdictions fluctuates widely. Until July 1968, a regulation of the Ontario College of Pharmacy limited the number of new registrants from outside jurisdictions who might be registered to one per cent of the total number of registrants per year. This limitation was withdrawn in 1968 and the number of new registrants from other jurisdictions increased substantially.

Of the 282 pharmacists on the Register in 1967 who were educated outside Ontario, the largest group, 144, came from other Canadian provinces, and fifty-two came from Great Britain. The other large group of forty-two emigrated from Eastern Europe, usually during periods of political upheaval in their home countries, and this source cannot be counted upon to continue.⁷ The conditions under which applicants from other jurisdictions are granted licences are described in a subsequent section of this chapter.

The number of retail pharmacies is decreasing. In 1968 there were 1,652 retail pharmacies — a decline from 1,787 in 1965, and 1,922 in 1955. Since 1962, the number of community pharmacies which were closed in Ontario has exceeded the number opened by more than thirty each year. In 1968 forty-eight more pharmacies were closed than were opened, and nine more communities were left without a retail pharmacy.⁸

Although the decrease in the number of pharmacies is not necessarily a cause for concern if it occurs in areas where pharmaceutical services are readily available, a decrease in the number of pharmacies in rural or northern areas which leaves areas without pharmacy service is of concern. A study of five rural Ontario counties showed that 72.7 per cent of the rural pharmacists had held their licences twenty years or more (provincial average, 54.5 per cent), while only 10.7 per cent of the rural pharmacists had been practising nine years or less (provincial average, 20.7 per cent). In pharmacy, as in medicine and dentistry, the younger practitioners tend to prefer the opportunities provided in large centres.⁹ Efficient utilization of professional services is difficult under rural conditions where the scale of operations tends to be small, and the pharmacy commonly is also a type of general store.

The supply of pharmacists from the University of Toronto Faculty of Pharmacy, given prospective rates of attrition among pharmacists, is not sufficient to maintain the present pharmacist:population ratio, or even the present absolute numbers of pharmacists. If rates of attrition were 3 per cent per year, more than 120 new registrants each year would be required to maintain the numbers of pharmacists at its present level. Given that the number of women practising pharmacy is growing rapidly, a 3 per cent attrition rate does not seem improbable, even allowing for the increasing tendency for women to remain in the labour force

⁷*Pharmacy, Vision and Hearing Services*, an unpublished study for the Committee on the Healing Arts, 1967.

⁸R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Tables A114, A117.

⁹*Pharmacy, Vision and Hearing Services*, *op. cit.*

for longer periods than in the past. The Dean of the Faculty of Pharmacy, University of Toronto, informed us that because of the limited capacity of the school, eighty qualified applicants were turned down by the faculty in 1968. This fact is significant. In general, we hold the opinion that, whenever possible, educational opportunities and facilities should be available to qualified Ontario students who have expressed a desire to be trained in any recognized health profession. That eighty qualified applicants were denied such opportunity in 1968 might in itself be taken as important evidence justifying the expansion of training facilities for pharmacists.

As mentioned above, a further consideration affecting the supply of pharmacists is the number of women entering the profession. Although pharmacy is a profession which can be practised part time — and indeed many small hospitals require the services of a pharmacist only part time — women often have different employment patterns than men because of marriage and child-bearing, and therefore shorter total working lives than men in pharmacy as in other professions. It is important to note that the proportion of women in pharmacy is increasing sharply. In the 1967 graduating class of the Faculty of Pharmacy, University of Toronto, 40.1 per cent of the graduates were women, as compared to an average of 5.5 per cent in the years 1926-1939. Of the 1,859 retail pharmacists who, in 1967, had held a licence for twenty years or more, only 124 were women, whereas of the 688 retail pharmacists who in the same year had held a licence for nine years or less, 149 were women.¹⁰ The present male:female ratio of the registrants with the Ontario College of Pharmacy is 3,786:674; however, the large number of men reflects the high proportion of pharmacists who acquired licences before the end of the Second World War. In the future, as the proportion of female graduates increases, it can be expected that larger numbers of pharmacy graduates will leave the profession at least temporarily after relatively few years of practice.

Although recent trends in pharmaceutical practice have increased the professional utilization of the pharmacist's time, we believe that other trends will increase the demands for the professional services of pharmacists in the future. Chemotherapy has become one of the major weapons of physicians in combating disease, and new technological developments in this field may be expected to augment drug utilization. Public health insurance schemes most likely will be extended to include drugs required for medical care, with a resulting increase in demand for pharmacy services. As well, the volume of prescriptions dispensed will tend to grow as the demand for health services generally continues to expand. Another source of demand for pharmacists is the hospital pharmacies. As an indication of the rising demand for hospital pharmacists, the December 1966 and January 1967 issues of the official publication of the Canadian Society of Hospital Pharmacists, Ontario branch, list a total of forty-three actual vacancies in hospitals in Ontario.

¹⁰*Pharmacy, Vision and Hearing Services, op. cit.*

The Committee received arguments from various bodies connected with pharmacy favouring the establishment of a second faculty of pharmacy in the province. These bodies included the Ontario College of Pharmacy, the Ontario Pharmacists Association, and the Faculty of Pharmacy of the University of Toronto.¹¹ Our own investigations led us to support this proposal. We believe that the development of a second faculty is greatly preferable to expansion of the Faculty of Pharmacy at the University of Toronto, not only because the possibilities for expansion at the University of Toronto are limited, but also because a second faculty situated elsewhere in the province will result in a healthy competition in educational programs and a better understanding of the relationship between the College and the educational institutions. In addition, the Faculty of Pharmacy at the University of Toronto informed us that it could not by itself provide an adequate program of continuing education for the pharmacists in the province.¹² Our recommendations regarding the need for measures to insure continuing competence of pharmacists will substantially increase the demand upon the teaching institutions of the province, since these institutions will be responsible for developing the programs. For this reason as well, we believe that providing two separate teaching centres will be advantageous. The question of the particular location and size of the second faculty should be determined by an appropriate body of educational experts appointed by the Department of University Affairs, and should be reviewed by the Coordinating Committee of the Cabinet on Health Education, a body whose creation is proposed in Chapter 24.

Recommendation:

107 That a second faculty of pharmacy be established at an Ontario university, as part of a health sciences centre, in order to maintain an adequate supply of pharmacists in the province of Ontario.*

Role of the Pharmacist

Retail Pharmacist

A pharmacist's function is to prepare and dispense drugs used in the diagnosis, treatment and prevention of disease. His principal professional duties, as outlined in the *Report of the Royal Commission on Health Services*, include "the compounding and dispensing of drugs prescribed by physicians and dentists, the determination of their potency, toxicity, therapeutic activity, dosage form, potentiality as compared with other drugs, synergism in combination, and the application of legal procedures in the use of drugs".¹³ The great preponderance of registered

¹¹Ontario Pharmacists Association, Brief to the Committee on the Healing Arts, 1967, p. 9, and Recommendation #5; Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, pp. v, 18, 29, 30; Ontario College of Pharmacy, Brief to the Committee on the Healing Arts, 1966, p. 2 (Recommendation S7).

¹²Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, p. 18.

*See minority opinion, p. 524.

¹³*Report of the Royal Commission on Health Services*, Vol. II, Queen's Printer, Ottawa, 1965, pp. 21-22.

TABLE 11.3
Distribution of Registered Practising Pharmacists in Ontario by Type
of Practice, 1967

Type of practice	Number of pharmacists
Retail	3,412
Hospital	281
Industry	68
Armed forces	10
Government	29
Total	3,800

SOURCE: *Pharmacy, Vision and Hearing Services*, an unpublished study for the Committee on the Healing Arts, 1967, as obtained from the Ontario College of Pharmacy.

pharmacists operate, or are employed in, retail pharmacies. Other institutions employing pharmacists include hospitals, government laboratories, pharmaceutical manufacturing establishments, and drug distributing firms. Pharmacists with graduate training may also be engaged in teaching and research.

The total number of pharmacists given in Table 11.3 is smaller than the total number of registrants in the Ontario College of Pharmacy for 1967 (4,347), since some registrants are not Ontario residents, while others are inactive or engaged in non-pharmaceutical pursuits.

The community or retail pharmacist sells a variety of goods. In addition to dispensing drugs and poisons that can be obtained only by prescription, he sells many non-prescription but restricted drugs. He may also sell a wide range of patent medicines and other consumer goods which are non-pharmaceutical. The division of the retail pharmacist's time between his two roles — that of a professional providing services in accordance with his expert knowledge, and that of an entrepreneur or salesman — varies according to the size and nature of the outlet in which he works.

The pharmacist must act in accordance with several types of controls. In the exercise of his professional duties, the pharmacist must check that each prescription brought to him was written by a qualified practitioner; and in cases of doubt about the accuracy of the prescription, he must verify it with the prescribing practitioner. Sales of poisons must comply with the exact procedures set out in the Pharmacy Act, including the keeping of a detailed account of each sale. A record must be kept of all sales or purchases of certain restricted drugs listed in schedules to the Pharmacy Act, and every prescription filled must be filed. The pharmacist must also comply with the conditions of the federal Food and Drug Act and Narcotics Control Act regarding the sale of restricted drugs and narcotics.

As approximately nine-tenths of all prescriptions filled utilize medicaments compounded by the manufacturer, the pharmacist no longer does any extensive

compounding himself.¹⁴ He must, however, maintain adequate inventories of drugs, and he must see that those drugs that, with time, have deteriorated below acceptable standards are discarded.

As we mentioned earlier, since 1967 there have been minimum standards established by the College regarding facilities and space of pharmacies, and the equipment used. There is, however, a great diversity in the size of pharmacies, the volume of sales, and the percentage which prescription sales form of the total sales.

Two seemingly opposing trends have developed in the past few decades. One is an increase in the number of purely professional pharmacies. The other is an increase in the number of large drug stores which, in addition to their dispensing departments, offer for sale a very wide variety of merchandising ranging from facial tissues to toys to chocolate bars. Both trends mark a shift away from the small, owner-operated pharmacy-variety store that still exists in many parts of Ontario.¹⁵

The amount of a pharmacist's time spent in dispensing varies widely. The Royal Commission on Health Services cited the 1962 Pharmacist Survey, which found that 45 per cent of retail pharmacists spent less than one-quarter, and 33 per cent spent between one-quarter and one-half, of their working time filling prescriptions.¹⁶ Retail pharmacists across Canada filled an average of only 2.2 prescriptions per hour, while hospital pharmacists filled 13.¹⁷ The brief of the Faculty of Pharmacy, University of Toronto, to this Committee states: "Studies have indicated that, on the average, approximately 50 per cent of the retail pharmacist's time is occupied in functions which are his direct and/or implied professional responsibilities under the Pharmacy Act, including, besides prescription services, the sale directly to the public of drugs, medicines, poisons, hospital and sickroom supplies."¹⁸

The amount of time spent in professional duties by the pharmacist is not necessarily a function of the volume of prescription sales in comparison to total sales, for both trends noted above would increase the professional utilization of a pharmacist. In a large drug store, the pharmacist may be completely occupied with dispensing work, with the general merchandising activities being handled by sales clerks. In a small drug store, where the volume of prescription sales is insufficient to occupy the full time of a pharmacist and sales help is limited, the pharmacist may spend well over half of his time selling general merchandise. The problem is compounded by the requirement that a registered pharmacist must

¹⁴*Ibid.*, p. 23.

¹⁵Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, Appendix A.

¹⁶*Report of the Royal Commission on Health Services*, Vol. II, *op. cit.*, p. 31.

¹⁷*Ibid.*

¹⁸Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, p. 25.

be on duty whenever the pharmacy is open, since there is at present no legal provision permitting the closing of only that part of the pharmacy where prescription drugs, poisons, and other drugs required to be sold by a pharmacist are kept. This requirement produces the greatest hardship for the owner-pharmacist in a small community where the demand is not sufficient to support two pharmacists. In larger communities the two trends noted above — that is, towards large variety drug stores and purely professional pharmacies — have encouraged outlets in which the volume of business is adequate to support at least two pharmacists.

We see no objection to the sale during non-dispensary hours of every preparation which may safely be sold by a non-pharmacist under present regulations. We believe, therefore, that the pharmacy should be permitted to remain open for the sale of non-restricted goods, even at a time when a pharmacist is not on duty. Such a provision, however, must be contingent upon the requirement that every preparation which can be sold only by a pharmacist be kept in a section of the store that can be closed and to which there is no access when the pharmacist is not present.

Recommendation:

108 That legislation be enacted to provide that retail pharmacies may remain open when a pharmacist is not on duty, provided that all drugs and medical preparations which, for the protection of the public, should be sold only by a pharmacist are included in a professional section, which must be closed in the pharmacist's absence.*

The institution of such arrangements should not provide a means by which one pharmacist might operate more than one store, giving only part-time prescription services in each. This would not provide the type of service which should be expected from a pharmacist. In some cases, however, particularly in small communities, a pharmacist might operate a pharmacy, and also provide part-time services at a local hospital, and the above recommendation would enable a pharmacist to undertake such service more easily. The Committee can see no objection to the development of pharmacy groups, in which the participating pharmacists may share the work load among two or more stores.

In recent years the pharmacist has often been viewed as little more than a "pill counter", a practitioner whose four years of training are underutilized. Those who hold this view cite the widespread use of precompounded medicaments, and the amount of pharmacists' time spent in non-dispensing activities.

Although we recognize the trend towards prepackaging and other technological developments in the drug industry, we do not regard pharmacists' services as diminishing in utility to the public. We believe that the pharmacist should be regarded as a professional practitioner and not a mere technician. In our view,

*See minority opinion, pp. 524-526.

the pharmacist must continue to be responsible for the accurate dispensing of prescriptions and for quality control. The introduction of hundreds of new drugs each year has forced both the retail and the hospital pharmacist to be cognizant of very many different compounds and substances, most of which may be dangerous to patients if misused.

The pharmacist also acts as a consultant to the general public and, to a lesser extent, may act as a check on possible physician errors in prescribing when such considerations as overdosage or incompatibilities may be factors. The pharmacist often advises his customers about cold or cough remedies, first aid equipment, and minor ailments which do not require the attention of a physician. Proper management of his inventories of drugs is also a most important function.

At present few physicians utilize pharmacists as "drug information specialists". However, given the changing educational arrangements of these two related professions, it is possible that in the future increasing numbers of physicians may come to regard pharmacists as useful consultants on pharmaceutical products, particularly in smaller centres.

A recent constructive step has been the institution by some pharmacists of patient record cards, listing all prescriptions issued to a customer. For a customer who regularly patronizes one pharmacy, such records can be an important safeguard against possible incompatibilities among various drugs prescribed by different physicians. We are not persuaded that pharmacists should be formally required to maintain such elaborate patient records at the present time, but we do believe that this practice is desirable in the long run.

Pharmacy in Hospitals

The role of pharmacists in hospitals deserves particular consideration. Although registered pharmacists do work in many hospitals in Ontario, there is no statutory requirement that hospital pharmacies must be operated by registered pharmacists. Section 2(j) of the Pharmacy Act, in fact, exempts from the provisions of the Act "the compounding, dispensing or supplying of poisons or drugs in any hospital or institution approved or licensed under any general or special Act".¹⁹ In 1965, some 35 per cent of the 179 hospitals in Ontario did not have the full or part-time services of a pharmacist, and of the eighty-three hospitals containing fewer than 100 beds, fifty-nine were without a pharmacist. A total of 290 pharmacists were employed in hospitals in 1965, but not all of these practitioners were registered pharmacists.²⁰

The functions of the hospital pharmacist vary greatly depending upon the size of the institution in which he works. In some smaller hospitals, the pharmacist works only part time, and spends most of that time dispensing, prepackaging and marking dosages. In larger hospitals, as well as performing regular dispensing

¹⁹R.S.O. 1960, c. 295, s. 2 (j).

²⁰Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, p. 28.

duties, the pharmacist may operate a drug information centre as a specialized service for the physicians and nurses in the hospital. The pharmacist also may assist the hospital's Pharmacy and Therapeutics Committee in the preparation of a basic formulary. The institution of a formulary in a hospital permits the pharmacist to make bulk purchases of one brand within a category of generic equivalents, instead of having to stock a number of brands of the substance. In some hospitals, especially those with teaching functions, the chief pharmacist coordinates his activities with other members of the health disciplines by assisting in the design and conduct of drug therapy trials, and by scrutinizing and regarding the system of drug dispensing throughout the hospital.

Hospital pharmacists see their role as providing assurances that all drugs ordered by physicians are appropriate for the patient and condition being treated with respect to such matters as dosage, method of administering, incompatibilities with other drugs prescribed, as well as stability and sterility over the time course indicated.

For many hospitals, however, the problem to be faced is not that of making the best use of the pharmacist's services, but rather of obtaining the services of a pharmacist at all. Salaries in hospital pharmacies tend to be lower than in community pharmacies, and this has resulted in unfilled positions. In smaller hospitals which cannot afford the full-time services of a pharmacist, occasionally an arrangement is made with a local community pharmacist to work part time in the hospital, an arrangement which is encouraged by the Ontario Hospital Services Commission (OHSC). In some areas, another possible solution to the problem of providing adequate pharmaceutical services in small hospitals may be to establish a combined hospital-community pharmacy within the hospital. This arrangement might increase the professional utilization of the community pharmacist's skills, and such possibilities should be explored wherever feasible.

We believe that increased utilization by hospitals of registered pharmacists should be encouraged, but that at the present time the relative scarcity of qualified personnel makes it impossible to require by statute the presence of a registered pharmacist in every hospital. We have not received evidence to indicate that abuses exist in hospitals at present in the dispensing of drugs, and the presence of physicians in the hospitals should provide some assurance of careful dispensing procedures even in the absence of a full-time pharmacist.

Recommendation:

- 109** That hospitals be encouraged but not required by law to have a registered pharmacist in charge of the pharmacy, and that there should be assurance of adequate control of drugs in every hospital. Where a hospital wishes and is able to hire registered pharmacists, the Ontario Hospital Services Commission should make proper provision in the hospital budget to pay a professional salary to such a pharmacist.*

*See minority opinion, p. 526.

With the increased resort by patients to emergency departments of hospitals as a result of changing patterns of medical practice, there is a growing need for the provision of pharmaceutical services in or near hospitals providing emergency service. It is anomalous that patients receiving medical care in hospital emergency departments may receive from a physician a prescription for therapeutic drugs, but may find it impossible to have the prescription filled by a pharmacy within a reasonable period of time if the emergency occurs at night or on a holiday. Even in large urban centres, patients in hospital emergency departments may receive a prescription and yet find difficulties in having the prescription filled as there is no open pharmacy within reasonable access. The Committee believes that if the emergency requires the administration of a drug, the patient should be able to obtain the drug as quickly and with as little inconvenience as possible.

Thus it is desirable that arrangements be made for the provision or sale of drugs to emergency patients within the hospital, and that this service should not necessarily be limited only to the amount required to carry the patient through the night, but for such longer periods as the physician may deem reasonable. Alternatively, it is desirable that private pharmacies be located in close proximity to hospitals providing emergency services, and that such pharmacies maintain around-the-clock dispensing hours whenever possible. If this alternative does not appear feasible, however, hospitals should provide such a service.

Recommendation:

- 110** That an emergency pharmacy service should be established in hospitals which would provide by sale such drugs as are necessary as part of emergency treatment at times or during hours when it would be difficult for emergency patients to have prescriptions filled by a retail pharmacy.

The Pharmacist and Chemotherapy

Rapid expansion of chemotherapy has been one of the most significant characteristics of the healing arts in recent decades. Drugs are often costly, and expenditures on drugs form a major part of total health expenditures. The Royal Commission on Health Services reported that prescription drug expenditures in 1961 were \$164 million, equivalent to about 43 per cent of expenditures on medical services.²¹ Within the past decade there has been much public concern over the costs of drugs to consumers, and the findings of the Sainsbury Commission in Britain, the Harley Committee on Drugs and Prices in Canada, and the Task Force on Prescription Drugs in the United States have confirmed the widely held view that the prices of some drugs are higher than they need to be. The Committee was not specifically directed by its terms of reference to inquire into the provision and costs of drugs to the consumer; nevertheless, we feel that we cannot ignore this important facet of the health services that links the functions of the physician and the pharmacist.

²¹*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, p. 345.

Drugs are a group of therapeutically active ingredients which can be identified by individual chemical names. The number of individual chemicals in a compound may result in a long and unwieldy chemical name. Hence a particular pharmaceutical nomenclature has been developed to be used in identifying and prescribing drugs. This abbreviated or "generic" name is used in pharmacopoeia and formularies. Brand or "proprietary" names on the other hand, designate the drug products of individual drug manufacturers. The brand names, which are usually easy to remember, are registered trade marks of the drug companies. While each product designated by a brand name also has a generic name, the drug company is naturally eager to encourage prescription of its own brand.

The market for drugs is exceptional in that the consumer, who pays for the product, has almost no choice in the selection of the drug, or in the choice of alternative drugs at different prices. It is the physician who must decide what drug to prescribe, and on his decision rests the health of his patient. He is therefore concerned primarily, not with the price of the product, but with the therapeutic effect; this, of course, should be the first consideration.

The multitude of new compounds available leads to confusion or uncertainty for many physicians who may have limited training in pharmacology and do not have the time to keep fully informed on rapid innovations in the development of new drugs. Evidence from both American and British studies indicates that probably a majority of physicians rely heavily upon the detail men of the different pharmaceutical companies, who, not surprisingly, lack impartiality, and upon manufacturers' literature for information about new drug products. Within Ontario, Dr. Clute in his survey of general practitioners, found that 32 per cent of the physicians surveyed did not feel that they had been well prepared by their medical training to evaluate the claims made for new drugs.²² It is therefore important that carefully prepared drug formularies be made available to all physicians, dentists and pharmacists who are required to use, prescribe or dispense drugs.

It has often been claimed that if physicians would prescribe generically, rather than by brand name, there would be major savings for the consumer. While the majority of the prescription drugs available are still under patent and therefore available only from a single supplier,²³ some products are produced by a number of companies by both brand name, and generic name, at a wide variety of prices. For the physician, however, there are difficulties encountered if he wishes to prescribe generically. If he is not sure of the chemical equivalency of similar drugs available from different manufacturers, he may prefer to specify a brand with which he is familiar, even if there is a generic equivalent available at a lower price.

The Committee has recommended in Chapter 8 (see Recommendation 26) that medical students be taught and physicians be encouraged to prescribe gen-

²²K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963, p. 354.

²³The Task Force on Prescription Drugs established a Master Drug List of the 409 most frequently prescribed drugs, accounting for 88 per cent of all prescriptions, and of them 293 were still under patent and available only from a single supplier.

erically. We realize that this recommendation cannot stand alone, for before the physician will prescribe generically he must have some assurance of the quality and safety of the product. Therefore, the provision of a formulary, or list of products which have met certain standards of quality, is a necessary step.

In 1968, the Ontario Department of Health set up the Drug Quality and Therapeutics Committee, an advisory committee to the Drugs and Biologicals Service in the Public Health Division of the Department. The Drug Quality and Therapeutics Committee is compiling a basic formulary or list of drugs which meet the quality criterion of the Committee. After the products are approved on the basis of quality, the marketing section of the Department's Drugs and Biologicals Pricing Program negotiates with the drug firms which indicate an agreed wholesale price at which the company will sell throughout the province to hospitals and pharmacies. These drugs will then be included in a comparative Drug Index, which will list similar drugs together with a comparison of their costs. The Index will include approximately 90 per cent of prescription drugs used in Ontario and will be published by the Department of Health. It will be sent to all Ontario pharmacies, physicians and hospitals, and will be periodically updated, with the initial edition planned for distribution in the summer of 1970. While the physician remains free to choose any medication he wishes, the Index will show him that there may be drugs, made by reputable manufacturers, available at a cost considerably lower than that of the brand he might otherwise prescribe.

The Department of Health has also been working with the Ontario Pharmacists Association to encourage the use of a fixed dispensing fee to be added to the cost of the ingredients. At the 1969 meeting of the Ontario Pharmacists Association, a majority of the members approved the concept of a fixed dispensing fee as opposed to percentage mark-ups in the cost of the ingredients, and in the autumn of 1969 the Department announced its intention to implement this scheme. It is anticipated that pharmacists will be encouraged through the Ontario Pharmacists Association to sign a letter of intent, and those who do so will be supplied with an identification symbol for their pharmacies to signify to the public that they cooperate with the program. The program will be voluntary for the pharmacists, and the agreed dispensing fee will represent a maximum fee, not necessarily a set fee.

We think these are constructive developments. It seems likely that there are substantial economies to be effected through substitution of generic drugs for brand name drugs. We are convinced that this Ontario Drug Pricing Program will benefit physicians, pharmacists and consumers in Ontario, and that it is not merely a desirable, but an essential, step towards more efficient and effective provision of drugs in Ontario.

A further desirable step towards the efficient provision of drugs in Ontario involves the extension of publicly financed health insurance coverage to the cost of drugs and pharmacy services required for medical treatment. Much of the contemporary practice of medicine necessitates the prescription of expensive drugs,

and many patients experience financial hardship because of the cost of such medication. If patients are unable to meet these costs, the result will be that medical treatment will remain inadequate and distortion of necessary medical services will occur. Although this Committee has not regarded the extension of publicly financed health insurance coverage to new disciplines as lying directly within our terms of reference, medical services are presently included under such coverage and we are of the opinion that services of a medical nature received by a patient should be insured whether these services are provided by a physician or other health practitioner. Accordingly, since chemotherapy is an integral part of much medical practice, it is essential that the cost of such therapy should not distort the pattern of the provision of health care.

Recommendation:

- 111** That an immediate review be made by the health insurance authorities of the Government of Ontario to study the inclusion of drugs and pharmacy services under publicly financed health insurance and to ensure that if these services are not immediately included, there is not a resulting distortion in the provision of health care.

The Pharmacy Assistant

The Committee feels that there is a useful, though probably limited, role which pharmaceutical assistants can play in large hospitals and large community pharmacies. Under the supervision of a pharmacist, a trained assistant can perform such functions as ordering and checking of inventories, obtaining prepackaged dosages, up-keep of records of sales and purchases of drugs and poisons, and dealing with mechanical parts of dispensing. The employment of a pharmaceutical assistant, however, would in no way lessen the responsibility of the pharmacist personally to read and interpret prescriptions, to select the pharmaceuticals unless the exact dosage is prepackaged, and to verify the labelled prescription. While we realize that such a semi-professional could be usefully employed only in a pharmacy that does a very large amount of dispensing, and that in the short run the demand for pharmaceutical assistants will be limited, nevertheless, in the light of the relative shortage of pharmacy manpower, we believe that utilization of pharmacy assistants can have real advantages. We believe that at least one training course for pharmaceutical assistants should be established as a pilot project, and that the appropriate location for such a course would be in a College of Applied Arts and Technology, preferably one already offering other courses in the health sciences. An educational advisory committee for auxiliary pharmacy personnel as discussed in Chapter 26 should be established in the Department of Education to advise on matters relating to length of programs, entrance requirements, and curriculum, and to accredit appropriate training programs.

As well, the Health Disciplines Regulation Board²⁴ should establish a classi-

²⁴See Chapter 25 for a description and discussion of the Health Disciplines Regulation Board.

fication of pharmacy assistant and an appropriate Division to develop standards of certification. Graduates of accredited training programs should be automatically certified.

Recommendations:

- 112** That the Pharmacy Act be amended to authorize the use of qualified pharmacy assistants working in pharmacies under the direction of pharmacists.*
- 113** That a pilot project be undertaken at a College of Applied Arts and Technology, preferably one already teaching in the health sciences, to establish an appropriate training course for pharmacy assistants.*
- 114** That pharmacy assistants be certified by the Health Disciplines Regulation Board, through a Division for pharmacy assistants.*

Education

At present there is only one school of pharmacy in Ontario, the Faculty of Pharmacy of the University of Toronto. Graduates from the four-year course receive a B.Sc. (Pharm.) degree, and are automatically registered as pharmacists by the Ontario College of Pharmacy without further examination, after fulfilling the

TABLE 11.4

Graduates from the University of Toronto, Faculty of Pharmacy, 1936-1968

Phm.B. degree			B.Sc. (Pharm.)	
Year		No.	Year	No.
1936-41	average	105	1952	23
1942-45	average	72	1953	45
1946		75	1954	45
1947		237	1955	40
1948		126	1956	68
1949		89	1957	86
1950		83	1958	80
1951		101	1959	85
1952		117	1960	67
1953		99	1961	72
1954		63	1962	63
			1963	96
			1964	84
			1965	98
			1966	87
			1967	74
			1968	84

SOURCE: Faculty of Pharmacy, University of Toronto.

*See minority opinion, p. 527.

apprenticeship requirements. The faculty was inspected in 1955 by the American Council on Pharmaceutical Education and was assessed as equivalent to a Class A School of the American Association of Colleges of Pharmacy.

There are two routes of entry to the pharmacy course. A student may enter the first year from Ontario's grade thirteen, or the equivalent, or he may enter the second year after one or more years of suitable university courses in science or pre-medicine. Three Ontario universities, Windsor, Ottawa and the Lakehead, offer pre-pharmacy courses which are equivalent to the University of Toronto's first pharmacy year, except for the substitution of a second year science course for the one pharmacy course taken by Toronto students in their first year. The undergraduate enrolment is limited to 130 in the first year, because of the restrictions of laboratory and teaching space.

The University of Toronto course attempts to give the student a broad background in the physical and biological sciences, extensive study of the four basic pharmaceutical sciences (pharmaceutics, pharmaceutical chemistry, pharmacology and pharmacognosy), and pharmacy administration, plus specialized study in the student's chosen field of practice: general or community pharmacy, hospital pharmacy, or research and industrial pharmacy. Those choosing the hospital pharmacy option in 1968 took part in a pilot project designed to foster closer understanding between pharmacy and medical students. These pharmacy students made hospital rounds together with medical students, internes and physicians. The purpose of this innovation is to give the prospective hospital pharmacist a clearer idea of the conditions for which drugs are prescribed.²⁵

An increasing number of students are taking graduate training, and are in demand for hospital pharmacy programs, for teaching, and for research in industry and government laboratories. The M.Sc. (Pharm.) degree was established at the University of Toronto in 1953, and the Ph.D. (Pharm.) in 1962. Since the introduction of these courses, fifty-three students have completed the M.Sc. program, with twenty-two working for it in 1968; and one person has completed the Ph.D. program, with four working for it. There are facilities for fifty graduate students at the University of Toronto.²⁶ Three hospitals — Women's College Hospital, Toronto; St. Joseph's Hospital, Hamilton; and Westminster Hospital, London — participate in a one-year postgraduate residency program in cooperation with the Faculty of Pharmacy. At the completion of the residency, the student receives a certificate in hospital pharmacy awarded by the individual hospital.

Evidence from the pharmaceutical bodies and from the study prepared for the Committee²⁷ indicates that there will be an increasing need for pharmacists with specialized graduate training in the fields of hospital pharmacy, research and

²⁵Information supplied by the Faculty of Pharmacy, University of Toronto, 1968.

²⁶*Ibid.*

²⁷Faculty of Pharmacy, University of Toronto, Brief to the Committee on the Healing Arts, 1966, p. 18.

teaching. We believe that study in such specialized fields should be available at the graduate rather than the undergraduate level.

Recommendation:

- 115** That programs of study in specialized areas of pharmacy be made available by faculties of pharmacy to pharmacists who have completed their undergraduate studies in pharmacy.

Although the College of Pharmacy has no formal control over the educational program of the University of Toronto Faculty of Pharmacy, there are many points at which the views of the College can be presented to the faculty through cross-representation on committees. Two members of the Ontario College of Pharmacy Council sit on the Faculty Council, and the Dean of the Faculty is *ex officio* a member of the Council of the Ontario College of Pharmacy. The College Registrar is a member of the University of Toronto Senate, which approves curriculum and examination changes, and he sits on the ten-member Board of Pharmaceutical Studies, together with three Senate members representing pharmacy graduates. This Board considers the curriculum before it is presented to the Senate. The Dean of the Faculty is a member of the Ontario College of Pharmacy Committee on Education, which examines the qualifications of applicants from other jurisdictions.

The Committee believes that control over education by the licensing body, whether formal or informal, should be eliminated, and has extended this principle to all disciplines. As noted above, the establishment of a second faculty of pharmacy may introduce a healthy element of competition and pluralism into the situation and decrease the influence of the licensing body over the educational bodies. We shall return to this subject later in this chapter (see p. 239).

As in the case of physicians and other senior health disciplines, we believe that practising pharmacists should be subject to a continuing education requirement. Programs of continuing education consisting of one and four-day seminars, and evening classes, are now conducted by members of the Faculty of Pharmacy in cooperation with the Ontario College of Pharmacy, working through the Faculty's Director of Extension Services, but these programs are not compulsory. Practising pharmacists have widely varying academic backgrounds, and although many of them take advantage of the courses and seminars offered, it is in the best interests of the public that all pharmacists maintain their competence. In Chapters 25 and 26, we discuss this matter in greater detail and in Chapter 25 make general recommendations for the development of procedures for ensuring continued competence (See Recommendations 321, 322 and 323).

Recommendations:

- 116** That a program for ensuring continuing competence be implemented for pharmacists and that periodically, perhaps every five years, every pharmacist in Ontario be required to present to the Ontario College of

Pharmacy a certificate from a faculty of pharmacy in Ontario stating that he has maintained a satisfactory level of competence in those areas of pharmacy in which he ordinarily practises.

- 117 That the Ontario faculties of pharmacy develop the standards and programs which would be required for such certification.

Regulation

The College of Pharmacy

The practice of pharmacy in Ontario has been governed since 1871 by the Ontario College of Pharmacy, which receives its powers from the Pharmacy Act.²⁸ The College maintains a Register of those practitioners qualified to practise pharmacy in Ontario, determines the qualifications necessary for an applicant for a licence, and enforces the standards of practice set out for registrants in the Act, the regulations and the by-laws.

The College is governed by a Council of sixteen members elected every two years, plus the Dean of the Faculty of Pharmacy, University of Toronto, as an *ex officio* member. Fifteen of the members are elected from fifteen electoral districts, while one member is elected by the registered pharmacists who practise in hospitals operated under the Public Hospitals Act. Five Committees are appointed by the Council to deal with specific areas of the College's activities: finance and property, education, infringement, discipline, by-laws and legislation.

To engage in retail pharmacy in Ontario, a pharmacist must be registered with the Ontario College of Pharmacy. Many licensed pharmacists do work in hospitals; however, there is no statutory requirement that hospitals employ licensed pharmacists. A physician may dispense drugs to his own patients in the course of his practice without coming under the purview of the College of Pharmacy; but if he wishes to operate a pharmacy, he must register as a pharmacist although he does not have to pass registration examinations.

The College maintains a Register of licensed practitioners, divided into three sections. Section I pharmacists are owners or managers of retail pharmacies, or chief pharmacists in a hospital with signing authority for narcotics, narcotic compounds, and controlled drugs. All these registrants are located in Ontario. In hospitals where there is no pharmacist, a physician signs for the narcotics. The College advises the Department of National Health and Welfare which of the Section I pharmacists fulfil the definition of "pharmacist" under Regulation 2(i) of the federal Narcotics Control Act, and of the regulations made under the federal Food and Drug Act (G.01.001.(h)), and therefore are allowed to purchase narcotics and controlled drugs.

Section II pharmacists have identical dispensing privileges but no signing or purchasing privileges of narcotics or controlled drugs. This category includes, in

²⁸R.S.O. 1960, c. 295.

addition to those actively practising pharmacy in Ontario, usually as employees of Section I pharmacists, pharmacists who are retired, or engaged in graduate studies or occupations other than pharmacy, or who are living outside Ontario. In 1968, 219 of the 2,114 Section II registrants lived outside the province. Only since 1952 have pharmacists other than owners and managers of retail pharmacies been required to pay annual fees and thus be included in the Register.

Section III of the Register lists corporations registered to operate retail pharmacies and those directors who are also pharmacists.

Section 34 of the Pharmacy Act requires that a majority of the directors of a corporation which operates a pharmacy must be registered pharmaceutical chemists; registered pharmaceutical chemists must also own a majority of the shares. The latter provision does not apply to corporations which operated a pharmacy prior to May 14, 1954.

In common with most regulatory bodies of self-governing professions, the Council of the College is empowered to pass by-laws, not requiring further authorization, to govern its internal administration. It also has been given the power by the Pharmacy Act to establish and maintain a school of pharmacy, a power which has been in abeyance since 1953. As noted in the section on education, however, there are close links between the College and the Faculty of Pharmacy of the University of Toronto.

Since the Pharmacy Act regulates both practitioners and the conditions of sale of drugs and poisons, the Council is empowered to discipline pharmacists and to prosecute breaches of the Act by non-pharmacists in provincial courts and can, with the approval of the Lieutenant Governor in Council, make regulations regarding the apprenticeship period, registration requirements and examinations, fees, the books, records and returns of pharmacies, and the standards for the maintenance and operation of pharmacies. Every person who opens a new pharmacy or acquires an existing one must furnish the Registrar with his name, address, business address and date of the commencement of operation of the pharmacy. Corporations operating pharmacies must notify the Registrar of the names and addresses and the numbers of shares held by directors and stockholders, since a majority of the directorships and shares must be held by registered pharmaceutical chemists.

Licensing

For graduates of the University of Toronto Faculty of Pharmacy, the further requirement for licensure is a twelve-month period of apprenticeship under the supervision of a pharmaceutical chemist who has been classified as a preceptor.²⁹

Applicants who are qualified to practise pharmacy in a jurisdiction outside Ontario must be resident in Ontario for the six months preceding the application,

²⁹R.S.O. 1960, c. 295, s. 18, and R.R.O. 1960, Reg. 480, s. 5, as amended by O. Reg. 187/66, s. 2.

fluent in the use of the English language, at least twenty-one years of age, be of good character, have been employed as a pharmacist in a retail or hospital pharmacy during any twelve consecutive months during the three years preceding the application, and have completed at least eighteen months' service as an apprentice.³⁰

In practice, each applicant from outside Ontario is interviewed by the Education Committee, and must provide letters from previous employers and the professional pharmaceutical association of which he is a member. If the academic qualifications of the applicant are not equivalent to the B.Sc. (Pharm.) degree of the University of Toronto, the applicant will be required to complete certain courses at the University of Toronto, or to pass certain of the degree examinations. Registration examinations for applicants whose academic qualifications are sufficient are conducted by the College.

There is no complete reciprocity of licensing between Ontario and other jurisdictions, although Council has the power to approve the registration without examination of applicants registered in other jurisdictions where Ontario pharmacists can register without examination. Completion of an examination in pharmaceutical jurisprudence, however, has always been required of such applicants. Applicants excused from examinations except in pharmaceutical jurisprudence come primarily from British Columbia, Saskatchewan and Great Britain.

Many of these restrictions on the ability of out-of-province pharmacists to be licensed in Ontario seem to us unnecessary. While we agree that pharmacists educated outside Ontario must understand and appreciate the laws pertaining to pharmacy in Ontario, appropriate instruction and examination should be easily available, and the pharmaceutical jurisprudence requirement should not delay unduly the applicant's entry to the profession.

Recommendation:

118 That the requirement of the College of Pharmacy that applicants from outside Ontario reside in Ontario for six months before being eligible to apply for licensing as a pharmacist be abolished, and that the requirement to complete a course in pharmaceutical jurisprudence not be permitted to delay unduly the applicant's entry to the profession.

Discipline

The Council of the College of Pharmacy can suspend or cancel the registration of a pharmaceutical chemist convicted of an offence against any Act relating to the sale of drugs, poisons, medicines, or alcoholic liquors; declared mentally incompetent or certified mentally ill; or guilty of negligence, incompetence, or improper professional conduct. The Council can also appoint inspectors who have the power to enter any pharmacy and to inspect the records which must be kept under the Act. The two sections of the Pharmacy Act that give rise to most of the violations discovered by the inspectors are section 37(1) requiring that a

³⁰R.R.O. 1960, Reg. 480, s. 14.

pharmacy be under the personal supervision of a pharmaceutical chemist at all times, and section 38 (1) limiting both the sale of drugs and poisons, and the compounding and dispensing of prescriptions to pharmaceutical chemists and internes.

Disciplinary procedures are dealt with by two committees. The Infringement Committee receives the reports of investigators and handles less serious matters of discipline. The more serious cases are referred to the Discipline Committee, which has the power to suspend or cancel the registration of a pharmacist or to issue a formal reprimand.

Routine inspections of every pharmacy in the province are made on the average of once every two years by the inspection staff of the College. This staff normally consists of four full-time inspectors who are also pharmacists and additional temporary staff from time to time for special investigations. As well as checking the records and the condition of the pharmacy, the inspectors advise pharmacists of new regulations, breaches of which might lead to disciplinary action. When a complaint is made to the College from other practitioners, the general public, physicians or the police, special investigators are hired who are non-pharmacists. The most common offences complained of are non-supervision of the pharmacy by a registered pharmacist, and dispensing or refilling without a prescription. Several visits will be made before a case is prepared against the registrant, and the investigation is under the supervision of the Infringement Committee.

Before 1961 all offences against the Pharmacy Act were prosecuted in magistrates' courts; since that time disciplinary matters have been dealt with by two Committees of Council, and only cases against non-pharmacists are taken to the courts.

The procedure in a hearing before the Infringement Committee is much less formal than that before the Discipline Committee, where the registrant is entitled to be represented by counsel, to present evidence and to cross-examine.³¹ There is no power to suspend a registrant during an investigation, a lack which could be serious in cases of alcoholism or mental incompetence. Although the Discipline Committee can cancel or suspend registration, it has no formal power to impose other conditions on a disciplined practitioner, such as to order him to sit a re-examination, nor is there any power to re-examine an inactive practitioner.

The major limitation on the control exercised by the College over the practice of pharmacy lies in its inability to supervise the dispensing of medical practitioners, or their lay help. In addition dispensing in a hospital clinic or nursing home does not come under the jurisdiction of the College, whether performed by a pharmacist or by lay personnel.

In practice, the College reinstates an applicant whose registration has been suspended after the period of suspension has elapsed, and permits a pharmacist

³¹*A Comparative Study of Discipline in the Healing Arts in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

whose registration has been cancelled to apply every six months for reinstatement.³² An appeal is permitted to the Ontario Court of Appeal within one month after suspension or cancellation of registration.³³

The Pharmacy Act

The present Pharmacy Act has two functions: to prescribe the composition and powers of the Ontario College of Pharmacy, and to regulate the sales of drugs and poisons within Ontario. The Committee believes that these two distinct areas should be covered by separate Acts. There should be a Pharmacy Act defining the composition and powers of the Ontario College of Pharmacy, which would continue to issue licences and regulate pharmacists. There should also be enacted a Sale of Drugs and Poisons Act under the jurisdiction of the Department of Health to regulate pharmacies and the sale of pharmaceuticals within Ontario. The Health Facilities Board, described more fully in Chapter 24, should be responsible for developing standards for pharmacies and for the inspection of pharmacies.

We believe that the establishment of such legislation will provide a more rational division of responsibilities, allowing the Ontario College of Pharmacy to concentrate upon its functions as a professional self-regulatory body. Moreover, in accordance with the principle which we are extending to all disciplines, we have recommended that the provision in the present Pharmacy Act giving the regulatory body the power to establish an educational institution be deleted from a revised Pharmacy Act.

Control over education of pharmacists by the College of Pharmacy initially was introduced because physicians and the public required assurance that pharmacists were competent to dispense drugs and the College was the only body which could provide that assurance. However, since the formal establishment of pharmacy as a university discipline in Ontario in 1953, the Faculty of Pharmacy at the University of Toronto has been able to assure the competence of its graduates, and control over education by the College has become superfluous. Moreover, the membership of the Faculty of Pharmacy in the Canadian Conference of Pharmaceutical Faculties, a voluntary association of eight Canadian schools of pharmacy which requires acceptance of minimum basic curriculum standards, and accreditation by the American Council on Pharmaceutical Education are evidence of sufficient checks upon the quality of education provided by the Faculty of Pharmacy, University of Toronto.

Recommendations:

- 119** That the Pharmacy Act be repealed and replaced by a new Act which would (a) provide for the regulation of the profession of pharmacy only, and (b) terminate the control of the Ontario College of Pharmacy over

³²*Ibid.*

³³S.O. 1966, c. 115, s. 6(2).

education. The Ontario College of Pharmacy should be continued, and should continue to be responsible for the licensing and discipline of members of the profession.*

- 120** That there be representation from the Department of Health and significant lay representation on the Council of the Ontario College of Pharmacy.
- 121** That separate legislation be enacted to regulate the sale of pharmaceuticals and the operation of pharmacies and that this legislation be administered by the Health Facilities Board in a manner similar to that now found in Part II of the Pharmacy Act for the regulation of pharmacies.

We are not persuaded that any great danger could result from permitting Ontario pharmacists to fill prescriptions written by physicians or dentists in other jurisdictions. In fact, in this age of high mobility and rapid travel, considerable inconvenience and pain may be occasioned to travellers from other provinces who are unable to have prescriptions filled or refilled while in Ontario. We believe such dispensing of prescriptions written by out-of-province practitioners should be permitted, although the Legislature may wish to exempt a specific list of narcotic drugs.

Recommendation:

- 122** That the Pharmacy Act be revised to permit pharmacists in Ontario to fill prescriptions of physicians or dentists in other provinces who are themselves qualified to prescribe in their own provinces.

The Committee believes that the patient is entitled to know the name of any drug dispensed to him, unless the physician specifically deems it not in the patient's best interests. We recognize that in certain cases the patient may associate the name of a certain drug with treatment of a disease more serious than the one for which he is being treated, and thus may become needlessly worried, or that some individuals are helped by the use of placebos, inactive agents which give the patient a sense of relief or security. The physician, however, may be expected to use his professional judgment to distinguish those patients who should not know the contents of their medication. We have also noted that the Pharmacy Act provides that a patient is entitled to receive a copy of the prescription from the pharmacist,³⁴ and we believe that this should be drawn to the attention of the public who may not be aware of this provision.

Recommendation:

- 123** That unless specifically directed by the physician not to label the prescription on each occasion, pharmacists be required to label each prescription dispensed as to the content and name of the drug contained therein.

*See minority opinion, p. 527.

³⁴R.S.O. 1960, c. 295, s. 48.

We understand that from time to time, some physicians, and apparently, particularly some rural physicians, upon deciding that a patient should have medication, deliberately refuse to write a prescription that could be filled by a pharmacist despite a request from a patient for a prescription, thereby depriving the patient of the option of having the prescription filled by someone other than the prescribing physician. In effect such a practice could, in relatively small communities, possibly lead to the pharmacist's going out of business with consequent loss to the community.

Clearly it is not desirable that a community be deprived of the services of a pharmacist by reason of the competition of physicians who dispense drugs directly to their own patients. Equally clearly, it is not necessary or desirable to prevent physicians from operating pharmacies or from providing drugs to their patients directly in emergency or other situations when the local pharmacy may be closed. The Committee was asked to recommend a statutory change to deal with the problem of physicians acting as direct economic competitors of pharmacists.

We recognize, however, that in many cases dispensing by physicians is done as a service to the patient because of the unavailability of pharmaceutical services within easy access. The study conducted by Dr. Clute, comparing the practices of general practitioners in Ontario and Nova Scotia, found that 39 per cent of doctors surveyed dispensed drugs in some volume in the course of their practice. It is significant, however, that only 19 per cent of the doctors located in centres with populations of over 10,000 dispensed, while 67 per cent of the physicians located in centres with populations under 10,000 did so.³⁵ We do not wish to limit in any way dispensing by physicians where it fills a real and obvious need. We believe that as there are many situations in which there are no alternatives to dispensing by physicians, on balance there is a net benefit in allowing physicians to continue to provide drugs to their patients directly when required.

Nevertheless, we believe that such dispensing, when performed on a regular basis, should be subject to the same requirements for accurate and complete records as is the dispensing by pharmacists, and we have made a recommendation in Chapter 8 (see Recommendation 24) accordingly.

However, the practice of depriving the patient of the option of having a prescription filled by a pharmacist, to the extent that it exists, is in our opinion undesirable, and we have no doubt that if such an occurrence were made out in a disciplinary proceeding, the College of Physicians and Surgeons would not hesitate to take appropriate disciplinary action against the physician. Accordingly, we have recommended in Chapter 8 (Recommendation 25) that physicians, at the request of a patient, supply to the patient a written prescription of any drugs prescribed for the patient unless the physician deems it not in the patient's interest on medical grounds.

³⁵K. F. Clute, *op. cit.*, pp. 74-75.

Corporate Practice

Prior to 1954, the corporate practice of pharmacy was permitted under the Pharmacy Act with the restriction that a majority of the directors of the corporation operating a pharmacy be registered pharmacists. However, when the Pharmacy Act was revised in 1953, a provision was added requiring that a majority of each class of shares of the corporation must be owned by, and registered in the name of, pharmacists.³⁶ This later requirement did not apply to any corporations operating a pharmacy prior to May 14, 1954.

Both the College of Pharmacy³⁷ and the Ontario Pharmacists Association³⁸ made representations to the Committee arguing that pre-1954 charters inactive for a period of twelve months be cancelled and urging reconsideration of the existing arrangements under which non-pharmacist controlled corporations operating pharmacies can continue to exist.

In the light of the available evidence, and in agreement with the recommendation of the Select Committee on Company Law (1967), this Committee has recommended that other health personnel be permitted to incorporate their practices (see Chapters 8 and 9). In general we do not believe that the existence of corporate practice presents any serious danger to the public interest.

Our studies suggest to us that the pharmaceutical industry has not been marked by strong elements of commercial competition; rather, the industry has tended to be one in which restricted entry to the trade has economic implications which may be contrary to the best interests of consumers. Thus we are not disposed to recommend steps which might further limit competition in this field, nor have we heard any evidence that the pre-1954 corporate charters have been abused. It is not desirable to interfere with existing vested rights unless there is a clear reason to do so. Therefore we do not recommend cancellation of these existing charters, but only constant review of the situation by the Department of Health.

On the other hand, we recognize that some danger to the public interest may be involved in any arrangement which would permit majority control of retail pharmaceutical corporations by non-pharmacists. Complete *laissez-faire* in this matter would enable literally any person or persons, entirely lacking training or professional status in pharmacy, to control pharmaceutical outlets and participate in the drug trade. Supervision of drug inventories and quality control measures might receive inadequate attention if commercial rather than professional considerations are given. Society has recognized that for the protection of the public, it is essential that pharmacists be highly trained professionals, and accordingly it has granted to pharmacists considerable powers of self-regulation and self-discipline. It would, therefore, be anomalous to permit non-pharmacists to acquire

³⁶R.S.O. 1960, c. 295, s. 34(2).

³⁷Ontario College of Pharmacy, Brief to the Committee on the Healing Arts, 1966, p. 35.

³⁸Ontario Pharmacists Association, Brief to the Committee on the Healing Arts, 1967, p. 7.

complete control of pharmaceutical outlets. We are not persuaded that it is necessary to exclude non-pharmacists from any participation in this retail trade, but we do regard as desirable retention of the present restriction regarding corporate practice so that, with the exception of the pre-1954 charters, control of pharmacies should remain in the hands of professional personnel.

Recommendation:

124 That no change be made in the law now found in the Pharmacy Act with relation either to the existing pre-1954 corporate charters, or to the existing requirement that majority control of incorporated pharmacies remain in the hands of licensed pharmacists; but that the matter of corporate practice be kept under review by the Department of Health.*

Voluntary Associations

Ontario Pharmacists Association

The voluntary association for registered pharmacists, the Ontario Pharmacists Association, has only 30 per cent of all registered pharmacists as members, although approximately 65 per cent of all retail store owners belong to it. Its aims are to promote the profession of pharmacy in Ontario, to encourage improvements in public health, to cooperate with other professional organizations having similar aims, and to foster liaison between the various branches of pharmacy.

TABLE 11.5
Membership in Ontario Pharmacists Association, 1930-1968

Year	Active	Associate	Total
1930	832	40	872
1940	821	30	850
1950	1,343	35	1,378
1960	1,300	101	1,401
1965	1,318	83	1,401
1968 ¹	1,235	65	1,300

¹Information received from Ontario Pharmacists Association.

SOURCE: Ontario Pharmacists Association, reply to Questionnaire "B", Committee on the Healing Arts.

Eight standing committees dealing with such subjects as marketing, health services, and the Pharmacy Act, cover various aspects of the profession, and the findings of some of the committees are outlined in monthly newsletters which discuss new regulations, marketing trends, and drug research. The Association has no compulsory requirement of continuing education for its members, but members are encouraged to avail themselves of the seminars and lectures sponsored by the Ontario College of Pharmacy. The Association has formal links with the Ontario

*See minority opinion, p. 527.

Medical Association through the Physician-Pharmacist Committee of the two bodies, and holds occasional joint executive meetings with the Ontario College of Pharmacy.

Canadian Society of Hospital Pharmacists, Ontario Branch

This voluntary Association is limited to those pharmacists who practise in hospitals. The Society was organized in 1947, and the Ontario branch was established in 1949. Its purpose is to promote the interests and extend the professional knowledge of hospital pharmacists. Approximately 56 per cent of Ontario's practising hospital pharmacists are members of the Society.

TABLE 11.6
Membership in the Canadian Society of Hospital Pharmacists,
Ontario Branch, 1948-1968

Year	Active	Associate	Honorary	Student
1948	25	22	—	—
1966	132	22	—	15
1967	156	20	3	40
1968	157	28	3	37

SOURCE: Canadian Society of Hospital Pharmacists, reply to Questionnaire "B", Committee on the Healing Arts.

The Ontario Branch cooperates with other organizations in the field of pharmacy, such as the Ontario College of Pharmacy and the University of Toronto Faculty of Pharmacy, through its Internship Advisory and Education Committees. Although members are not required to take continuing education courses, the Branch encourages such programs. It prepares annual reports of salaries, jobs, and salary recommendations for its members, hospital administrators, and pharmacy organizations. Student interest in hospital pharmacy is fostered through the provision of speakers for careers programs, and support of the Ontario Hospital Association's Orientation to Hospital Pharmacy program conducted for community pharmacists.

Chapter 12 Optometrists, Ophthalmic Assistants and Ophthalmic Dispensers

The Committee has observed that misunderstandings, tensions and conflicts commonly occur between various healing disciplines. In few areas of our inquiry is such conflict more pronounced than in the field of vision care. The discipline of optometry illustrates some of the most difficult problems of interdisciplinary relations in the healing arts.

Within the field of vision care there are two types of independent practitioners: physicians, and particularly ophthalmologists; and optometrists. An ophthalmologist is a physician who has taken three years of specialist training in vision care with major emphasis on diseases of the eye and surgery, leading to specialist certification by the Royal College of Physicians and Surgeons of Canada, and who may have taken an additional year of training in surgery or general medicine to qualify for a Fellowship. There are also physicians, apart from ophthalmologists, who devote a substantial proportion of their practice to eye care. An optometrist is a non-medical practitioner who has direct contact with the public without the mediation of a physician. Both the optometrist and the ophthalmologist are qualified to examine patients and prescribe corrective measures where there is no indication of disease, but only the ophthalmologist is qualified to treat pathological conditions of the eye. There are wide, if one-sided, areas of overlap, however, between the two categories of these medical and non-medical practitioners. Ophthalmologists deal with both healthy and diseased eyes; optometrists claim that, while they do not treat diseases of the eye, they are trained to detect them. Thus the heart of the problem of optical services is related to the continuing controversy over the limits of the practice of optometry and the determination of what care optometrists should provide, a complicated and technical question.

In the first part of this chapter we deal with the practice of optometry, including its relationship to the practice of ophthalmology; in the second part we discuss ophthalmic dispensers; finally, in the third part we consider ophthalmic assistants. Much of the information in this chapter is based on *Pharmacy, Vision and Hearing Services*, an unpublished study for the Committee on the Healing Arts, 1967.

Optometrists

History and Legislation

In the mid-nineteenth century, the modern scientific approach to vision care was developed and two kinds of opticians, or suppliers of spectacles, emerged. Dispensing opticians supplied spectacles only on the prescription of a physician, whereas refracting opticians adapted lenses independently, measuring vision and being paid on a fee-for-service basis. The term optometry was first used in 1877 to describe the procedure of measuring the refraction of the human eye.¹

In the twentieth century optometrical training in Ontario gradually developed from an informal apprenticeship system to a five-year university course. During the period 1900-1920, although some optical laboratories offered short training courses, the usual method of optometrical training was to serve as an apprentice to a practising optometrist. In 1909 the Optometrical Association of Ontario was incorporated. A voluntary association, it organized conventions and worked for the establishment of formal optometrical training. This objective was supported by the Royal Commission on Medical Education in Ontario — 1917, which included optometry in its study. The Commission recommended that a two-year training course be established and that instruction be given in anatomy, physiology, ocular pathology, and the detection of diseases of the eye.

The 1919 Optometry Act² was the first statute to regulate optometry. It provided for a Board of Examiners in Optometry, with five members to be appointed by the Lieutenant Governor in Council for a five-year term. Subject to the approval of the Lieutenant Governor in Council, the Board was empowered to make regulations regarding the training and education of optometrists, and the qualifications for registration which became mandatory for future practice. The Board also could revoke the certificate of practice of any optometrist found guilty of illegal practices, incompetence, inebriety, fraud or misrepresentation.

In 1920 a one-year training course was established at Central Technical School in Toronto. This program was subsequently extended to two years in 1925, when the Board of Examiners founded the College of Optometry under the authority of the Optometry Act, to three years in 1936, and to four years in 1952. In 1957 the curriculum was revised. The four-year program was maintained and the entrance requirements set at grade thirteen or the equivalent. In 1961 the Optometry Act³ was re-enacted and with it the Board of Examiners, established by the 1919 Act, was replaced by the College of Optometrists. In 1967 the training school was transferred from the College of Optometry of Ontario, in Toronto, to the Faculty of Science, University of Waterloo. This program now consists of one year of pre-optometry and four years of professional training, leading to an O.D. (Doctor of Optometry) degree.

¹Ontario Medical Association, Brief to the Committee on the Healing Arts, Appendix V, Ophthalmology, 1967, p. 120.

²S.O. 1919, c. 19.

³S.O. 1961-62, c. 101.

Manpower

As Table 12.1 and 12.2 indicate, the number of optometrists in Ontario has been declining since 1951, both absolutely and relative to the size of the population. In the 1930's and 1940's, more optometrists entered the field than in the 1950's because the training program was shorter in the earlier period. It appears that subsequent increases in training requirements may have contributed to the recent decline in the number of optometry graduates. Between 1952 and 1968, limited educational facilities kept the numbers of graduates relatively low. Also, as a result of the shift to a four-year course in 1952, there were no graduates in 1955. Finally, during the transition period occasioned by the transfer to the University of Waterloo, enrolments were low between 1967 and 1969, as compared with the anticipated enrolment for 1970.

The expanded training facilities at the University of Waterloo are intended to produce approximately fifty graduates per year in the 1970's, some of whom are expected to locate in Ontario. Thus it is anticipated that the increased capacity of the School of Optometry will reverse, or at least offset, the trend towards declining numbers of practitioners.

There are very few foreign-trained optometrists practising in Ontario. Of the twenty-eight non-Ontario residents registered with the College of Optometrists in the period 1952-1968, twenty-three were from other parts of Canada and five from outside Canada. Only 3 per cent of optometrists are female.

The geographical distribution of optometrists is fairly wide in Ontario. According to a 1963 survey by the Optometrical Association of Canada, there were resident practising optometrists in 108 of the 126 cities and towns of Ontario with a population of over 3,000 people, and in ten with a population of under 3,000. The eighteen larger centres without resident optometrists had regular visiting optometrists. In 60 per cent of the communities in Ontario where optometrists practise there is no other practitioner trained in vision care to provide these services.⁴

TABLE 12.1
Practising Optometrists and Population per Optometrist,
Ontario, 1931-1967

Year	No. of practising optometrists	Population per optometrist
1931	625	5,490
1941	646	5,863
1957	665	6,913
1961	533	11,699
1967	522	13,816

SOURCE: For 1931-1961, *Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, p. 291, Tables 7-33. For 1967, College of Optometrists of Ontario.

⁴College of Optometrists of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 4.

TABLE 12.2
Practising Optometrists in Ontario, 1951-1968
(including part-time practitioners)

1951	670
1957	665
1960	548
1961	533
1962	533
1963	533
1964	527
1965	521
1966	525
1967	522
1968	519

SOURCE: College of Optometrists of Ontario, Communication to the Committee on the Healing Arts, August 1968.

Role of the Optometrist

Under the Optometry Act, optometry is defined as follows:

... the services usually performed by an optometrist, including the measurement of or the attempt to measure, by any means other than the use of drugs, the refractive or muscular condition of the eye, the prescribing and ophthalmic dispensing of ophthalmic appliances, and prescribing ocular calisthenics for the relief or correction of any visual or muscular error or defect of the eye.⁵

The optometrist's functions cover five aspects: diagnostic, advisory, therapeutic, prescriptive and dispensing to his own patients. During an examination, optometrists attempt to detect and measure optical defects and structural defects of the eye, irregularities in eye movement, the presence of disease or sensory defects, and abnormal conditions produced by environmental influences. Once the problem is diagnosed, the optometrist either treats it himself or, if the nature of the problem is beyond his competence to treat, refers the patient to an ophthalmologist or other medical specialist. The application of ophthalmic devices such as lenses, contact lenses, prisms and filters to correct vision defects is one method of treatment used by the optometrist. Another is the prescription of orthoptics, a technique of eye exercises designed to correct eyes which are not properly coordinated for binocular vision, and vision training to correct strabismus and other binocular vision defects. Finally, the optometrist checks and fits the ophthalmic appliances he has prescribed, and may fit the ophthalmic appliances prescribed by ophthalmologists.

⁵S.O. 1961-62, c. 101, s. 1(h).

Thus, optometry has been confined by law to refraction, a scientific measurement of the refractive error of the eye and treatment of any errors, detection and non-operative treatment of muscle imbalance, and the prescription of accurately correcting lenses, while ophthalmology has embraced both refraction, and the diagnosis and treatment of pathological conditions and other abnormalities of the eye which may be related to pathological conditions elsewhere in the body. In recent years, the early diagnosis of any abnormality in the eye has become a matter of increasing concern, and great advances have been made in both detection and treatment. Although ophthalmologists still have the primary responsibility for the care of the eye beyond refraction, the increasingly sophisticated skills of the optometrists enable them to contribute towards the early detection of pathological conditions. The alleged ability of optometrists to extend their skills into this area has brought about some degree of overlap or duplication of skills between optometrists and ophthalmologists. Inevitably, this overlap has been a major cause of tension between the two disciplines.

Ophthalmologists, who receive three or four years of further training after their medical internship, are the most intensively trained and most highly qualified group of practitioners within the field of vision care. But the services of ophthalmologists are in relatively short supply; there are too few practitioners to provide adequate services, including refractions, for the entire population. In 1966 there were only 210⁶ ophthalmologists in Ontario (including those in retirement), a figure which yields a practitioner:population ratio of 1:32,500. Nor is there any encouraging indication that the number of ophthalmologists can or will be increased markedly in the foreseeable future.⁷ The training of these specialists takes between ten and twelve years, and in 1967 there were only thirty-eight ophthalmology students engaged in postgraduate training in Ontario.

The exclusive use of ophthalmologists for vision care services is both impracticable and wasteful of highly trained specialists. This makes it all the more imperative that decisions be made to improve the present and future effectiveness of optometrists in the health delivery system.

In the majority of cases, when a patient having eye trouble visits an optometrist, his eyes will be healthy, although a prescription for eye glasses may be required to correct abnormal vision. With these cases there is no cause for concern. But an important issue arises in connection with those patients whose symptoms are the result of pathological conditions of the eye or other systemic disease.

The major reservations expressed by members of the medical profession — in particular ophthalmologists — concerning the alleged inadequacies and dangers to the patient in the practice of optometry relate to the following considerations:

⁶Royal College of Physicians and Surgeons of Canada, reply to Questionnaire "A", Committee on the Healing Arts.

⁷See *Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, p. 48.

- 1) The limited capacity of optometrists to perform accurate diagnoses of pathology.
- 2) The hazards of permitting optometrists to use diagnostic drugs.
- 3) The inability of optometrists to treat and offset physical reactions of patients to the application of diagnostic drugs.
- 4) Since vision defects in the very young are often symptoms of pathological conditions elsewhere in the body, the inappropriateness of permitting optometrists to diagnose and correct vision defects in small children.

The present courses in the two schools of optometry in Canada now provide sound training in optics and refraction. The optometrical course at the University of Waterloo has been increased in length from four to five years. Attempts have been made to acquire the services of ophthalmologists and other medical and scientific specialists to participate in the education program. While it is not surprising that the medical profession in general, and ophthalmologists in particular, have serious reservations about the practice of optometry and about permitting medical specialists to take part in optometric education, the Committee is strongly of the view that there is no justification for practitioners of any healing discipline to impede or obstruct improvements in the education program of any related discipline when that discipline has an acknowledged basis in the scientific method.

Ideally, practitioners of all professions in the health field should be trained in a common institution and be exposed to as many joint programs as possible, not only for economic reasons, but also in order to establish better understanding between the different professions. Beginning as early as 1962, the Ontario College of Optometry made repeated attempts to have its educational facilities incorporated into a university in which a faculty of medicine exists, so that its students might be trained in a centre where other health sciences are taught and educated as part of a health team. These efforts were unsuccessful.

When first planning its move, the College of Optometry had been in contact with the provincial government — both the Minister of Health and the Minister of Education, and latterly the Minister of University Affairs — about finding it a university home. The Minister of University Affairs subsequently asked the University of Waterloo to give consideration to this request. In a Committee of the Senate of the University of Waterloo, it was agreed that optometry, properly organized, is a respectable branch of science, worthy of degree status.⁸ The transfer was approved by the Minister of University Affairs and the Minister of Education, and in the summer of 1967 the College of Optometry hurriedly (because of the prospective expropriation of its building by the University of Toronto) moved from

⁸Report of the Committee to Investigate Education of Optometrists in Ontario, University of Waterloo, 1964, p. 6.

Toronto to the University of Waterloo. It is important to note that the negotiations were conducted with the Department of University Affairs rather than with the Department of Health, which appears to have been caught unawares by the decision. The story illustrates the lack of coordination between planning agencies concerning an important development in the health field.

The Committee finds it unfortunate that the College of Optometry has chosen to locate in a university which has no medical school or school of pharmacy, and which teaches no major health sciences.

Recommendation:

- 125** That no movements of educational facilities connected with the healing arts be allowed without the prior consultation of the appropriate authorities including the proposed Coordinating Committee of the Cabinet on Health Education, the Department of Health, Department of Education and the Department of University Affairs.

While it is understood that both ophthalmologists and optometrists have contributed to the misunderstandings and tensions which exist in the field of vision care, the Committee has come to the conclusion that organized medicine has taken an excessively narrow view of the practice of optometry, a view which is a hindrance both to the optometrists' attempts to improve the quality of their education, and to the development of efficient vision care services in the province.

In 1967, the Judicial Council of the American Medical Association stated that it was not unethical for a physician to teach in a recognized school of optometry, and more recently pronounced that a physician may refer his patients to a qualified and ethical optometrist for optometric services.⁹ But the Constitution of the Canadian Ophthalmological Society,¹⁰ a voluntary organization of ophthalmologists in Canada, prohibits its members from teaching other than medical or paramedical personnel. This seems to us contrary to the best interests of the public and the health care system. (See also Recommendation 27, Chapter 8.)

Recommendation:

- 126** That the medical profession not interfere with the choice of any of its members to participate in the education of optometrists, and that no segment of organized medicine interfere with the freedom of any physician to teach in a school of optometry and participate in its educational program.

As the section on optometrical education will reveal, optometrists display a considerable degree of responsiveness to changes in technology. They have made earnest efforts to adopt new techniques as part of their practice, and to improve

⁹*Journal of the American Medical Association*, Vol. 205, No. 13, September 23, 1968, p. 9.

¹⁰Constitution of the Canadian Ophthalmological Society, Article XVII, Ethics.

the scientific content of their education. We are persuaded that optometrists place a suitable emphasis on their responsibility for referral of those conditions which they detect as being beyond the range of their practice. We have heard no allegations that optometrists fail to detect pathological conditions where such conditions exist, or that they are unwilling to refer to medical specialists cases which involve pathological conditions, and we are satisfied that such referrals do occur whenever pathology is detected. At present, however, optometrists are prohibited by law from using diagnostic drugs. The primary drugs called for during eye examinations are in the form of drops and are of two types: cycloplegic drugs, which relax the focusing muscle of the eye, dilate the pupil, and allow an examination of the interior of the eye; and anaesthetic drugs, which render painless certain portions of the eye that may cause discomfort when examined. Both drugs are used also in detecting glaucoma and other diseases of the eye. The Committee believes that, given the present shortage of ophthalmologists, more danger to the patient exists through restricting the diagnostic functions of optometrists than through permitting them to use the appropriate techniques to detect a pathological condition, and then to direct the patient to a physician. The Committee believes that such dangers as may exist through acts of omission by optometrists can be prevented in large measure, if the above recommendation and the following recommendations are implemented. This conclusion is consistent with that of the Hall Commission.¹¹

Recommendations:

- 127** That the Optometry Act be amended to permit the use by optometrists of drugs needed for diagnostic purposes, provided that undergraduate programs in the use and effect of such drugs are instituted, and that optometrists now practising who wish to use drugs meet the requirements of a postgraduate course to be offered by the School of Optometry.
- 128** That the expanded diagnostic functions of the optometrist should not be construed as an invitation to treat pathological conditions of the eye but rather to enable optometrists to be in a better position to make referrals of patients requiring medical care to an ophthalmologist or other appropriate physician.

The Committee is concerned that the public may be misled as to the qualifications and identity of the practitioner they choose. Accordingly, as we have recommended in relation to other disciplines, we believe that restrictions on the use of the title "Doctor" must be continued.

Recommendation:

- 129** That optometrists continue to be prohibited by law from using the title "Doctor", with or without a qualification.

¹¹*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, pp. 48-50.

The treatment of children presents special problems. Because strabismus and reading difficulties may be early signs of serious eye or brain disease, and because the diagnosis and management of both may require the combined efforts of many disciplines (including those of the paediatrician, neurologist, ophthalmologist, otolaryngologist, psychiatrist, psychologist, social worker and teacher), the Committee believes that optometrists should not be permitted to initiate independently the treatment of children under six years of age. The Committee finds, however, that restricting vision care services for children under six to ophthalmologists may cause hardship in those areas where no ophthalmologist is accessible.

Recommendation:

- 130** That children under six years of age be permitted optometric care by an optometrist only on referral from a physician.

The Committee has considered the development of group practice for the delivery of health services in other contexts, particularly in Chapter 29 of this Report, and believes that the concept of the health care team is one that can be applied usefully to the field of vision care services. If optometrists in the future are enabled to practise in close physical and professional liaison with medical practitioners, important safeguards can be introduced to facilitate referral of pathology, and to render immediate treatment to any patient suffering physical reaction to the application of diagnostic drugs. There is a strong case for optometrists to be employed, as they are now in the Canadian Forces Medical Services, under the general direction of ophthalmologists in "eye clinics" or in multi-disciplinary community health clinics — modes of practice which permit each practitioner to concentrate on that field of service in which he has been most highly trained. In short, the merits of the practice of optometry are likely to be more extensive, and undoubted, when optometrists are integrated effectively into the health care system.

Recommendation:

- 131** That the Government of Ontario, and bodies responsible to it, take appropriate steps to encourage and facilitate the inclusion of optometrical practice in group practice teams, community health centres and hospitals.

Until recently, the Ontario Medical Services Insurance Plan paid only for the services of licensed medical practitioners in the field of vision care. In many geographical areas there was no practitioner other than an optometrist who could provide vision care services. Thus, the patient had to pay a fee for a benefit included in his plan, and for which he had paid a premium, because the designated practitioner was not available. This not only was an injustice to the patient, but unnecessarily increased the work load of the already overburdened ophthalmologist. The Committee also sees as positive any moves to improve the accessibility of

total vision care services. The continued inclusion of optometrical services under publicly financed health insurance plans will assist the population in obtaining improved vision care.

Organization of Practice

In the past optometry has lent itself easily and efficiently to private practice. The optometrist has not normally required hospital facilities; hence the availability or lack of such facilities has not affected the location of practice. The majority of Ontario practitioners presently engage in private practice (450 of the 533 practising in 1965).¹²

A 1966 survey of the Canadian Association of Optometrists which questioned 212 Ontario optometrists found that 180 reported their source of income as private or individual practice; fifteen, as partnership; eight, salaries; six, salaries and commission; and three unknown.¹³ Among those who reported their method of practice as private or individual, however, were some who were associated with, or worked within the premises of, a commercial establishment such as a jewellery store or a department store. Some optometrists who work in this manner are paid on a salary or commission basis. Under section 15 of the Optometry Act, corporate practice in optometry is permitted, for a lay person can maintain "an optical department at his place of business where the profession of optometry is practised", if the department is run by an optometrist or by a duly qualified medical practitioner. Approximately 11 per cent of Ontario optometrists practise in such retail outlets.¹⁴

Group practice has begun to develop among optometrists, although it is not yet widespread. In large centres especially, proximity of offices permits a certain degree of specialization in such fields as orthoptics or subnormal vision treatment. There are two instances in Ontario of optometrists working as part of a health care team, in the Group Health Centres in Sault Ste. Marie and St. Catharines.

An advanced form of group practice is the Optometric Centre of New York, which has a professional staff of forty-two optometrists, two ophthalmologists, two psychologists and a research librarian. There are a number of clinical departments in such fields as visual analysis, contact lenses and tonometry. A wide range of research is conducted there, as well as continuing education programs for optometrists.¹⁵

Most optometrists, then, work individually in private offices, having direct first contact with the patient and receiving payment on a fee-for-service basis. The Optometrical Association of Ontario publishes a suggested minimum fee

¹²College of Optometrists of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 2.

¹³Canadian Association of Optometrists, Economic Survey for 1966.

¹⁴*Ibid.*

¹⁵College of Optometrists of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 24.

schedule to which the members of the Association voluntarily subscribe. As of July 1, 1968, optometrical services came under the services covered by OMSIP, with a standard fee allowed for an optometrical procedure, which was defined in O. Reg. 212/68 made under the Medical Services Insurance Act, 1965 as an examination of the eyes, particularly by refraction, for the purposes of determining a requirement or otherwise for corrective lenses.

Education

As the section on the history of optometry indicated, by 1952 the study of optometry had moved from what was an apprenticeship system to a formal four-year course. From 1927 to 1954, arrangements were made with the University of Toronto for teaching basic subjects such as mathematics, physiology, psychology, physics, anatomy, zoology and optics. Optometry students were registered as "occasional" students of the university and were allowed to use university facilities. The arrangement ended in 1954 because of the large postwar university enrolment. This change inevitably caused a setback in enrolment until new facilities could be constructed. In 1957 the College of Optometry was accredited by the Council on Education of the American Optometric Association, and the accreditation has been extended to the new School of Optometry at the University of Waterloo.

The education of optometrists has been shaped by a number of influences. One is the increasing emphasis on the study of basic sciences and the theory of vision, as well as on clinical procedures; another is the continuing tension between members of the medical profession and optometrists, a tension reflected in the by-law of the Canadian Ophthalmological Society mentioned earlier (see page 250) and which in effect prohibits an ophthalmologist from teaching in a school of optometry. The optometrists' struggle for recognition as competent and legitimate health "professionals" has not been encouraged by the official attitudes of ophthalmologists.

Ontario residents have frequently formed a minority of the graduating class because Ontario has the only English-speaking school of optometry in Canada. The majority of Canada's practising optometrists are graduates of the College of Optometry, while the University of Montreal supplies almost all Quebec's optometrists.

The course at the University of Waterloo now consists of five years, after grade thirteen: one pre-optometry year, and four years of optometrical training. A student can take the pre-optometry year at any university which offers the requisite subjects. The University of Waterloo can enrol a maximum of fifty-five in the pre-optometry course, for which the entrance requirements are at least 60 per cent in five senior matriculation subjects, including physics, chemistry and mathematics A. The school was planned for a total capacity of 212 students in the four optometry years. During 1968-1969, the total enrolment was 109. The enrolment for 1969-1970 totals 224, including sixty students in the pre-optometry year. After the second optometry year, a student may transfer into a general science program and receive a B.Sc. after a further year of study.

TABLE 12.3
Graduates from the College of Optometry, 1952-1968

Year	Total number of graduates	Ontario residents
1952	31	16
1953	16	7
1954	17	8
1955	none — changed to a four-year course in 1952	
1956	7	3
1957	10	5
1958	9	7
1959	8	4
1960	5	4
1961	6	3
1962	9	5
1963	14	6
1964	16	11
1965	22	12
1966	20	12
1967	19	7
1968	23	6

SOURCE: College of Optometrists, Communication to the Committee on the Healing Arts, August 19, 1968.

TABLE 12.4
Percentage of Practising Optometrists in Canada Who Are Graduates of the Ontario College of Optometry, by Province, 1966

Ontario	94.3
British Columbia	63.6
Alberta	66.7
Saskatchewan	90.7
Manitoba	80.0
Quebec	1.2
New Brunswick	44.4
Nova Scotia	75.0
Prince Edward Island	50.0
Newfoundland	58.3

SOURCE: Canadian Association of Optometrists, Economic Survey for 1966.

The first two years of the optometry course concentrate on general and basic science subjects. In the third year, greater emphasis is placed upon clinical subjects, and four hours a week are spent in the clinic with a further sixty hours of clinical practice during the summer term. In the final year, twenty-two hours a week are spent in the clinic and fourteen hours at lectures and laboratories. The clinic has six departments to provide a wide range of experience for the student: vision analysis, binocular vision, subnormal vision, contact lenses, pathology, and ophthalmic dispensing. One morning a week is spent outside the school in community work. In Toronto, prior to 1967, community work took the form of school vision surveys, industrial vision surveys, and vision care services for Runnymede Hospital.

The degree awarded is O.D., Doctor of Optometry. We have already expressed our concern that the public may be misled by the use of the title "Doctor" and stated that the use of this title within the health system should be restricted to physicians and dentists only. The Committee therefore regrets the decision of the University of Waterloo to award a doctorate degree, because this would appear to imply that graduates have the right to use this title in practice. We would urge the university to reconsider this decision and award instead a Bachelor's degree in optometry on completion of the professional training in optometry.

As yet there is no program of graduate study for optometry in Canada, although the University of Waterloo hopes to initiate one by 1970. A graduate program would provide useful training for future teachers and researchers, and for the planning of public or private vision care programs in schools and industry.

In 1957 an opportunity was provided for practitioners to update their standards by means of a two-year program sponsored by the College of Optometrists. A course was begun involving directed extramural study and attendance at the College of Optometry for one week of intensive study. This program is no longer offered; however, a number of refresher courses were offered each year to practising optometrists. These were conducted by the School of Optometry. In 1968 three courses were given: one in paediatric optometry, from May 20-23; one in contact lenses and corneal pathology, from May 23-30; and one in applied bacteriology for optometrists, from June 17-28.

In view of the fact that the knowledge of a healing art quickly becomes obsolete, it is an increasingly important condition of modern practice that there exist programs of continuing education. (See discussion in Chapter 25.)

Recommendations:

- 132 That a program for ensuring continuing competence be implemented for optometrists and that periodically, perhaps every five years, every optometrist in Ontario be required to present to the College of Optometrists a certificate from a school of optometry in Ontario stating that he has maintained a satisfactory level of competence in the practice of optometry.

- 133** That the School of Optometry develop the standards and programs which would be required for such certification.

In Chapters 25 and 26, we indicate in some detail our views concerning the desirability of separating control of education from professional licensing bodies. These considerations are particularly relevant in the case of optometry now that the School of Optometry exists within a university faculty of science. Although the Board of Directors of the College of Optometrists cannot prescribe the course of instruction for the new School of Optometry, as it did for the College of Optometry in O. Reg. 166/63, s. 2 made under the Optometry Act, candidates for the registration examination must have taken an equivalent course to that outlined in those regulations. The University of Waterloo, School of Optometry, provides such a course. In general, however, the Committee believes that there are other methods of assuring maintenance of standards of education, and does not accept the view that regulatory bodies should continue to determine the education of future practitioners.

Recommendation:

- 134** That the control of education of optometrists be removed from the College of Optometrists and the Optometry Act, and that graduates in optometry from the School of Optometry at the University of Waterloo or from any other Ontario university that may hereafter establish a school of optometry be licensed without further examination by the College of Optometrists.

Contact Lenses

The Committee recognizes the dangers that can result unless the whole process of examination, fitting and post-fitting of contact lenses is properly supervised. While total elimination of this problem is impossible, there are safeguards which must be applied to ensure that every person who wishes to purchase contact lenses is treated only by practitioners qualified to do so.

The Committee believes that optometrists have received adequate training in the application of contact lenses and has seen no evidence which would contra-indicate their continuing to prescribe and dispense them. But although ophthalmic dispensers certainly do not prescribe but can convert a prescription for eyeglasses to contact lenses, the Committee finds this dangerous since not all persons can safely use contact lenses.

Recommendation:

- 135** That contact lenses be dispensed only on a written prescription for contact lenses of an optometrist or an ophthalmologist.

Regulation

The licensing and regulatory body for optometry in Ontario is the College of Optometrists. The College is administered by the Board of Directors, a body of five elected members. After being nominated and seconded by optometrists in his district, one member is elected from each of the eastern, western and northern electoral districts, and two from the central electoral district, for a three-year term of office. Balloting is carried out by mail, and the voter may vote only for a nominee from the electoral district in which he practises. The Registrar of the College is appointed by the Board. An annual meeting is held at which the Board must give an account of its activities.

It is necessary to be a registered member of the College of Optometrists to practise in Ontario. There are three kinds of membership: life membership, for persons who reach an advanced age; non-practising members, limited to those who were already registered as non-practising members on January 1, 1966; and practising members. The College periodically publishes a Register of practitioners authorized to practise.

Requirements for obtaining a licence to practise are laid down in section 8 of the Optometry Act.¹⁶ An applicant must be more than twenty-one years of age, of good moral character, and a graduate of a school or college of optometry recognized by the Board; and he must possess the general educational training and experience qualifications prescribed by the regulations. Candidates for the registration examination must have taken an equivalent course to that outlined in the regulations. Candidates from outside Ontario must either have completed a course equivalent to that outlined in the regulations or have been practising as optometrists and thus received training which the College deems equivalent to the outlined course.

Of course, not all practitioners have the educational qualifications outlined in the regulations, because they were established in practice before the requirements were laid down. In 1966 there were still six practitioners who had trained under the apprenticeship system. In the case of foreign applicants for registration, the practice has been to examine the course of study and training received by the applicant. If the applicant is a graduate of an accredited American school, where the course is six years, he is permitted to take the registration examination. If, however, the applicant has not received what the Board considers equivalent training, he will be so advised and will have to provide evidence of graduation from an approved institution, having been given credit for his previous training, before he is allowed to try the registration examination.

After writing and passing the examination of the Board, the applicant is registered as an optometrist. The registration fee is fifty dollars and the annual fee is \$100. A fee of \$100 also is charged for sitting for the Board examinations. Registration certificates must be renewed annually.

¹⁶S.O. 1961-62, c. 101, s. 8.

In discussing the regulatory arrangements of other health professions in previous chapters, we have indicated that for some of the more senior health professions it would be difficult to alter a long-standing principle of self-regulation. In these cases we have recommended that public representation be added to the licensing body. We believe this principle ought to apply to optometrists as well.

Recommendation:

- 136** That the College of Optometrists of Ontario continue as the licensing body for optometrists, but that there be representation from the Department of Health and significant lay representation on the Board of the College of Optometrists.

Under the authority of section 12 of the Optometry Act, the Board operated the College of Optometry in Toronto until 1967, when the new school of Optometry was opened as part of the Faculty of Science at the University of Waterloo. Although the Board does not control the admission requirements and curriculum of the new School as it controlled those of the College of Optometry, there is a close liaison between the faculty and Director of the School, and the Board of Directors of the College, and the two bodies meet together twice a year. We have already recommended that the licensing functions and the educational functions be separated (see Recommendation 134).

The Board is empowered both to make by-laws¹⁷ and to formulate regulations.¹⁸ By-laws are rules respecting the administration of the affairs of the College, a self-governing body, and are subject only to the approval of the members of the College at the annual meeting. Regulations, in contrast, are rules dealing with policy matters affecting the public, and as such are subject to the approval of the Lieutenant Governor in Council. The Board can recommend regulations respecting the following matters: admission requirements and courses of instruction for the College of Optometry (superfluous since 1967); the holding of examinations for registration; the registration of candidates; the suspension and cancellation of registration of optometrists, and the issue and renewal of certificates of registration; the government and discipline of the members; the defining of unprofessional conduct; and the prescribing of fees for registration and examinations. The Board has no control over prices charged for spectacles, or fees for service.

There are four standing committees of the Board, the structure, activities and appointments of which are laid down in the by-laws. Each committee has not more than five members, appointed by the Board and including at least two members of the Board. The Financial Committee reviews the current and future financial affairs of the College.

¹⁷S.O. 1961-62, c. 101, s. 7.

¹⁸*Ibid.*, s. 16.

The Education Committee, which before 1967 reviewed the affairs of the College of Optometry, now works with the Discipline and Legislation Committee concerning the upholding of standards of practice among the members. It also maintains a close liaison with the School of Optometry and makes suggestions concerning undergraduate and refresher courses. One of the members of this Committee is a representative of the School of Optometry, appointed by the president of the University of Waterloo. The Liaison and Legislation Committee makes recommendations regarding the revision of passing of by-laws and regulations.

The Discipline Committee receives and deals with complaints about the members, and enforces the provisions of the Optometry Act, the by-laws and the regulations. Under section 10 of the by-laws, the Discipline Committee may hire investigators and after receiving a complaint in writing against a member may interview witnesses, the complainant and the member. After investigation, the Committee may dismiss the complaint, reprimand the member, recommend to him means of avoiding further complaints, or refer the matter to the Board for a public hearing.

Under section 11 of the Optometry Act, the Board may suspend or revoke the registration of an optometrist found guilty of unprofessional conduct as defined in the regulations, or of incompetence or misrepresentation. Under the definition of unprofessional conduct, the optometrist is prohibited from using any title other than that of "optometrist"; from encouraging or permitting the unqualified practice of optometry; from splitting fees; from advertising, except through professional cards, appointment cards, small newspaper announcements, reminder notices, one professional sign and doorplates; from signing or issuing documents containing misleading information, or withholding information which should be disclosed; from submitting false or misleading accounts; from prescribing or dispensing ophthalmic appliances without using "reasonable and appropriate clinical procedures"; and from failing to keep a record of the procedures used and the findings obtained. Any member charged with a violation of any of these prohibitions has the opportunity of appearing at a public hearing and presenting evidence there. The president or vice-president of the Board has all the powers of a commissioner under the Public Inquiries Act at such a public hearing. A member may appeal an order or finding of the Board to a judge of the Supreme Court of Ontario. The Committee believes that an appeal procedure is not only desirable but essential; and as we indicate in Chapter 25 we concur with the recommendations of the Report of Royal Commission Inquiry into Civil Rights in this regard.

Ophthalmic dispensers and qualified medical personnel are exempted from the provisions of the Optometry Act.¹⁹ The Board, however, administers section 15 of the Act which requires that a retail merchant who operates "an optical goods department where optometry is practised" must place the department under the charge of a registered optometrist or qualified medical practitioner, and must file

¹⁹S.O. 1961-62, c. 101, s. 13.

with the Board annually the name and address of the owner or manager of the business, and of the optometrist or medical practitioner. Because the College of Optometrists is concerned with the danger of overprescribing in such cases, and with its "professional image" and the lack of control that can be exercised over advertising in the case of retail merchants hiring optometrists, it has proposed that the above section 15(a), subsections 1 and 2, be removed from the Act and that a regulation be passed classifying such practice by a member of the College as "unprofessional conduct". The Committee, however, has found no evidence to warrant removal of the section.

Recommendation:

- 137** That no change be made in the Optometry Act, section 15(a), subsections 1 and 2 and that a retail merchant should not be prevented from employing an optometrist or operating an optical goods department.

The College of Optometrists believes that optometrists should show separately in their billings to patients the charges for professional fees and for the cost of ophthalmic appliances supplied. It also suggested to the Committee that it be a matter of unprofessional conduct for optometrists to charge a profit on ophthalmic appliances.²⁰ The College maintains that such a requirement would eliminate the opportunity for optometrists to overprescribe.

We agree that the separation of professional fees and charges for goods would be advantageous to the patient and place the billings of optometrists on a similar basis to those of other health practitioners. This in itself should be an adequate safeguard against overprescribing, as the patient would then have information on the cost of goods with which he could compare the prices of other suppliers if he so desired. If, however, the College of Optometrists still wishes to declare such mark-ups as unprofessional conduct, we do not believe they should be precluded from taking this action.

Recommendation:

- 138** That the Optometry Act require that optometrists submit to their patients an itemized bill showing charges for professional fees and charges for goods supplied; and that, if it wishes, the College of Optometrists be empowered to declare as unprofessional conduct any mark-up by an optometrist on ophthalmic appliances.*

Nothing in the Ophthalmic Dispensers Act prevents the sale or offering for sale of spectacles or eyeglasses by a retail merchant at his place of business; but

²⁰College of Optometrists of Ontario, Brief to the Committee on the Healing Arts, 1967, pp. 19-20.

*See minority opinion pp. 528-529.

the Lieutenant Governor in Council may make regulations governing or restricting such sale, or offering for sale and prescribing the terms and conditions thereof, and designating the material and kind of spectacles and eyeglasses that may be sold under this section.

The Board of Ophthalmic Dispensers has expressed a desire that this section be deleted or reworded to prevent the sale of eyeglasses over the counter.²¹ It argues that, although the eyeglasses are not necessarily a danger in themselves, a potential danger lies in undetected conditions of the eye that should be treated by an ophthalmologist or optometrist. The Committee recognizes that there is potential harm, particularly to children, from such sales but feels that this only provides a further argument for the expansion of professional vision services for elderly people and also in the school system for children. No real evidence of harm from such sales has been submitted to us.

Recommendation:

- 139** That the sale of ready-to-wear eyeglasses by a retail merchant at his place of business not be prohibited, but that there be no change in the present provisions of section 21(a) of the Ophthalmic Dispensers Act which provide that "the Lieutenant Governor in Council may make regulations governing or restricting such sale or offering for sale and prescribing the terms and conditions thereof and designating the material and kind of spectacles and eye glasses that may be sold out of this section".

The Committee has considered the problems involved in requiring or not requiring re-examination for refilling of prescriptions for eyeglasses and believes that this should be the individual's decision. If a person has simply broken his eyeglasses, he should not be required to have a re-examination in order to have them replaced. The Committee believes that any such requirement is unnecessary from a health standpoint and would be unduly expensive to the public.

Recommendation:

- 140** That ophthalmic dispensers not be prohibited from refilling prescriptions for eyeglasses without re-examination, and that an optometrist or ophthalmologist provide a patient with a written prescription after an examination to permit the patient to retain the prescription and choose his own supplier.

In practice, the Board has had to deal with very few serious discipline matters. The majority of complaints involve infringements of the advertising regulations; in these cases, the Chairman of the Discipline Committee usually obtains a written

²¹Board of Ophthalmic Dispensers, Brief to the Committee on the Healing Arts, 1967, pp. 11-12.

acknowledgement of the breach from the member and a promise to remedy it. No full-time investigatory staff is maintained, and on only two occasions has it been necessary to employ professional investigators. Only one case, involving a mentally incompetent practitioner, has required a public hearing before the full Board. No regular inspections of the quality of work performed or of the premises of practitioners are carried out, although a newspaper clipping service is maintained.

Voluntary Association

Approximately 72 per cent of Ontario practitioners were members of the Optometrical Association of Ontario (OAO) as of 1966. A Council of twelve members, six of whom constitute the Executive, heads the Association. The Council appoints an Administrative Director, who is responsible for general management and for relations with other healing professional groups and government departments. Councillors are elected for two-year terms from ten electoral districts. One councillor is elected from each of nine electoral districts, while three are elected from the tenth (Toronto) district. Nominations are made by active members, and the balloting is conducted by mail.

There are four categories of membership: active; associate (non-practising optometrists); honorary, conferred by the Council; and life (members over seventy years of age). Only members in the first and last categories are entitled to vote and hold office. The requirements for membership are registration as an optometrist under the Optometry Act and agreement to abide by the constitution, by-laws, code of ethics, and code of professional conduct of the Association. There are no requirements for continuing education of members, but the OAO does sponsor educational seminars and publicize other educational activities.

The OAO exists to promote the welfare of its members through various activities. To pursue its aims, the Association has set up a number of committees: Education, which plans seminars and lectures, and maintains a close liaison with the College of Optometrists; Membership and Finance; Public Information; Student Affairs, which gives information to students and guidance counsellors; Occupational Vision; Legislation and Legal Affairs; Motorists' Vision and Highway Safety;

TABLE 12.5
Membership in the Optometrical Association of Ontario, 1930-1969

1930	302
1940	346
1950	363 of which 330 Active
1960	380 of which 353 Active
1969	399 of which 367 Active

SOURCE: Optometrical Association of Ontario, reply to Questionnaire "B", Committee on the Healing Arts for 1930-1965, and direct communication from the Optometrical Association of Ontario for 1969.

Ethics and Professional Conduct; Department of Social and Health Trends; Inter-professional Relations; Problems of Children and Youth; Geriatric and Sub-normal Vision; Practice Management; Insurance; and National and International Liaison. To promote the aims of the Association the committees prepare briefs; maintain contact with government departments, members of Parliament and local councils; prepare press releases and public information programs; and conduct negotiations with insurance companies.

The OAO sends a newsletter to all its members. It also publishes a suggested schedule of fees for examination, refraction, prescribing, dispensing, verification and fitting, contact lenses, subnormal vision treatment, and optometric services to industry, hospitals and schools.

In 1952 the adoption of the code of professional conduct led to the separation from the Association of optometrists who practise commercially. Commercial practice was defined as "the operation of the practice itself, or of an optical department, store or other outlet, for purposes of profit from the sale of optical supplies and/or ophthalmic materials". Other provisions of the code prescribe that members must put the patient first, respect their colleagues, and refer a patient who requires care beyond the scope of optometry; and they must not use any misleading title. Members must restrict their advertising to regular professional signs and business cards, and must not display ophthalmic appliances. Fee splitting and rebates are prohibited.

With optometrical services now covered under OHSIP, the Committee desires that the fee schedule for optometrical services, like the services of other major healing groups, should not be set unilaterally but should be negotiated by the Optometrical Association of Ontario and the Minister of Health, advised by the Fee Negotiations Advisory Committee, as recommended in Chapter 24.

Recommendation:

- 141** That the fee schedule published by the Optometrical Association of Ontario be a matter of prior negotiation by the Association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.²²

Public Health in the Field of Vision Care

With the increasing awareness of the need for proper vision care as a prerequisite for normal educational progress, and the ever-increasing industrialization of society, there is a manifest need for a more extensive public health program in the field of vision care. Dependence solely on ophthalmologists to carry out such programs would limit the extent and scope of such services, due to the shortage of such personnel. We believe, therefore, that it is most important that the competence of

²²See Chapter 24.

optometrists to do this work be recognized; they have the further advantage of being more widely distributed throughout the province than are ophthalmologists.

It has been established that optometry in Ontario is a major resource for vision care and sight conservation, and therefore should be of considerable importance in providing community services in the field of public health. At present utilization of optometrists in public health programs is minimal. In spite of not being integrated into the province's system of public health, through local and private arrangements optometrists increasingly are being involved in providing such community services as the following: 1) vision care for needy children; 2) vision care programs in the schools; 3) vision requirements for motor vehicle operations; 4) industrial and vocational vision programs; and 5) vision rehabilitation for the perceptually handicapped child.

We noted that schools of optometry reflect this need, and courses are offered in visual development, school vision screening and treatment programs, industrial and vocational vision, vision requirements of motorists, and vision problems of the aged. We are convinced that it is necessary to provide high quality and readily accessible services to school-aged children and to the aged through screening and clinics.

The municipal health department of Scarborough clinic conducted a multiphasic screening test in April 1968, in which a total of 17,072 were tested for glaucoma, tuberculosis and diabetes; 649 cases of abnormal pressure, a symptom of glaucoma, were discovered. This is one example of the services provided by local public health departments. Such services should be extended and put on a regular basis. In the Scarborough screening, ophthalmologists and nurse technicians were used. The Committee feels that in such mass screenings and examinations to discover the vision problems of particular individuals and groups, a much greater use can be made of optometrists: they should be represented on public health agencies and utilized in public health programs.

Ophthalmic Dispensers

Under the Ophthalmic Dispensers Act, ophthalmic dispensing is defined as follows:

- i. supplying, preparing and dispensing ophthalmic appliances [which are further defined as lenses, spectacles, eyeglasses, artificial eyes, contact lenses or appurtenances thereto for the aid of correction of visual or ocular anomalies of the eye].
- ii. interpreting prescriptions of legally qualified medical practitioners and optometrists; and,
- iii. the fitting, adjusting and adapting of ophthalmic appliances to the human face and eyes in accordance with the prescriptions of legally qualified medical practitioners or optometrists.²³

²³S.O. 1960-61, c. 72, s. 1(d).

The ophthalmic dispenser sells ophthalmic appliances to the patient after a fitting process which involves taking measurements of the pupils and face of the patient; selecting a frame which is comfortable, while positioning the optical centre of the lenses in the required position; and checking the strength and fitting of the lenses after they have been prepared.

Legislation

Prior to 1960, ophthalmic dispensers were licensed under the Optometry Act. Under the Ophthalmic Dispensers Act passed in 1960, provision was made for a Board of Ophthalmic Dispensers to administer the Act and regulations.

Manpower

In 1969 there were 470 dispensing opticians in Ontario, seventeen of whom were certified as contact lens fitters.²⁴ This figure includes active practitioners, licensed dispensers working in laboratories, and those who had retired.

The "ideal" ratio of ophthalmic dispensers to ophthalmologists is considered by the Ontario Association of Dispensing Opticians to be 2:1.²⁵ Although ophthalmic dispensers claim a relatively large shortage of personnel, such a shortage, if it exists, is not reflected in a long waiting time for service. Prompt service is likely a function of the high productivity of large optical firms.

Organization of Practice

Three basic types of practice exist: corporations with many retail outlets; "professional type" outlets, located in or near professional buildings; and other outlets often associated with jewellery or watch repair shops, or department stores.

Education

The requirements for a licence are set out in section 7 of the Ophthalmic Dispensers Act, which reads as follows:

7. Every applicant for registration as an ophthalmic dispenser who furnishes satisfactory evidence that he,
 - (a) is over twenty-one years of age and is of good moral character; and
 - (b) has
 - (i) completed a *course of study in a school of ophthalmic dispensing* approved under the regulations and has had *practical training* for one year in Canada with an ophthalmic dispenser or optometrist; or

²⁴Board of Ophthalmic Dispensers, Communication with the Committee on the Healing Arts, January 11, 1969.

²⁵Ontario Association of Dispensing Opticians, Brief to the Committee on the Healing Arts, 1967, p. 2.

- (ii) completed at least *three years training and experience* in ophthalmic dispensing, at least one of which was in Canada, under the supervision of a legally qualified medical practitioner, wholesale optical company, ophthalmic dispenser or optometrist; and has completed a *home study course* as prescribed by the regulations; or
- (iii) in the opinion of the Board, the qualifications and experience equivalent to that set forth in subclause i or ii and has had one year's experience in Canada, under the supervision of a legally qualified medical practitioner, wholesale optical company, ophthalmic dispenser or optometrist;
- (c) has passed the examination of the Board; and
- (d) has paid the prescribed fee,
shall be registered as an ophthalmic dispenser.²⁶

At present, in Ontario the formal education of ophthalmic dispensers is a compulsory home study course. It commenced in 1963 and is under the supervision of the Board of Ophthalmic Dispensers. The course lasts two years and includes one week of lectures given in June of each year at the Ryerson Institute of Technology. The home study course, the curriculum of which is prescribed in Regulation 6 of the Ophthalmic Dispensers Act, is taken during the last two years of the three years of practical training, as specified in section 7(b) (ii), under the supervision of a qualified ophthalmic dispenser. Before the student ophthalmic dispenser writes the Board examinations, he must have completed grade ten.

From October to May, assignments are sent out based on prescribed texts, and only if the assignments are successfully completed is the student permitted to attend the lecture course. In the first year the course covers basic studies in light, lenses and the anatomy of the eye; the second year covers dispensing techniques, including a study of the fitting of different types of lenses. In 1969 there were fifty-eight students in the first year of the home study course, and forty-one in the second year.²⁷

TABLE 12.6
Graduates of the Home Study Course, 1964-1966¹

1964	27
1965	37
1966	29

¹The Committee received no figures for 1967 and 1968.

SOURCE: *Pharmacy, Vision and Hearing Services*, an unpublished study for the Committee on the Healing Arts, 1967.

²⁶S.O. 1960-61, c. 72, s. 7 as amended by S.O. 1965, c. 93, s. 1. (Emphasis added.)

²⁷Board of Ophthalmic Dispensers, Communication to the Committee on the Healing Arts, January 11, 1969.

The Committee has noted the past utility of the training of ophthalmic dispensers through a home study course plus practical training; however, we believe that serious planning of a full-time course should be undertaken. The present system of apprenticeship may tend to restrict the supply of trained personnel. The Committee thus would like to see the alternative of formal training introduced whenever feasible. The Committee has noted that because of the relatively small number of ophthalmic dispensers, more than one formal training program would not be required at this time.

Recommendations:

- 142 That the Department of Education encourage the development of a formal training program for ophthalmic dispensers in either a College of Applied Arts and Technology or a technical school, and that the requirements for licensing of ophthalmic dispensers be changed to include such a training program and to provide for the licensing of its graduates as ophthalmic dispensers, provided that they serve a further period of one year under the direction of a licensed ophthalmic dispenser or other appropriate person as the legislation may permit.
- 143 That an Ophthalmic Dispensers' Educational Advisory Committee be appointed to advise the Minister of Education on matters pertaining to the education of ophthalmic dispensers and to review the educational programs for ophthalmic dispensers and examine the product of the formal training program to determine whether the entire period of training for ophthalmic dispensers might be shortened or converted to this system.

Although ophthalmic dispensers have argued that the present entrance requirement of grade ten should be changed to grade twelve, the Committee did not find that the evidence presented warranted either change or any overall extension of the period of training.

Recommendation:

- 144 That the present entrance requirement of grade ten to undertake training as an ophthalmic dispenser should not be changed, and that the overall period of training should not be extended beyond that presently required.

All ophthalmic dispensers are licensed to fit contact lenses on a prescription from an ophthalmologist or optometrist. But the Board is encouraging specialization in this field. A postgraduate home study course has been established, leading to certification by the Board as a contact lens technician. In conjunction with specified readings over one year, the practitioner must keep detailed records of a prescribed number of cases of contact lenses which he has fitted. At the end of the year these records are reviewed; if they are approved, the practitioner is permitted to do two weeks' intensive work at the contact lens clinic of the Toronto Western

Hospital. After completion of this work he tries written and oral examinations to qualify for certification. There are presently twenty-three contact lens students.

This course is voluntary. The Committee believes that the only way to ensure that future ophthalmic dispensers will have the basic training required in contact lens fitting will be to have that training and experience included in the basic training of the ophthalmic dispenser, and thus to have all ophthalmic dispensers certified as contact lens technicians.

Recommendation:

145 That training and experience in fitting of contact lenses be included in the basic training of the ophthalmic dispenser either in the proposed new system of education or under the present system, with appropriate examinations being conducted at the completion of the training, and that all ophthalmic dispensers successfully completing the training be certified as contact lens technicians by the Health Disciplines Regulation Board.

At the same time, the Committee is concerned that existing ophthalmic dispensers involved in fitting contact lenses should have at least some training in the problems and possible hazards of such procedures.

Recommendation:

146 That the fitting of contact lenses by ophthalmic dispensers be limited to those practitioners who have successfully completed the necessary courses in contact lens fitting and have been certified as a contact lens technician by the Health Disciplines Regulation Board.²⁸

Regulation

The Ophthalmic Dispensers Act established the Board of Ophthalmic Dispensers to administer the Act and regulations. The Board is composed of five members appointed by the Lieutenant Governor in Council for a two-year term. The chairman, vice-chairman and secretary-treasurer are elected by the members of the Board from among themselves. The Board members also appoint the various committees.

Only persons licensed under the Ophthalmic Dispensers Act of Ontario can practise as ophthalmic dispensers. Persons so licensed practise under the general supervisory jurisdiction which the Act has given the Board. The Board keeps a Register of all persons entitled to practise, and of student ophthalmic dispensers.

Every optician licensed under the Optometry Act in 1960 became licensed automatically under the Ophthalmic Dispensers Act — a total of 157 opticians.

²⁸See Chapter 25.

A further 154 practitioners were licensed under section 9 of the Ophthalmic Dispensers Act, the "grandfather clause", which provided that persons who had practised as ophthalmic dispensers for at least three years in Ontario and were so certified by an ophthalmologist could be licensed within a year after the Act came into force. A further thirty-two persons were licensed under this clause after they had passed examinations set by the Board of Ophthalmic Dispensers.

The present requirements for licensing are set out in section 7 of the Act, referred to in detail earlier in this section. The applicant must be over twenty-one years of age and of good moral character. He must have completed the prescribed course of study, passed an examination set by the Board of Ophthalmic Dispensers, and paid the initiation fee of fifty dollars. The Committee does not think that the arbitrary setting of an age requirement for practice is warranted for any health discipline. We regard this as yet another example of the unfortunate tendency of many disciplines to upgrade unnecessarily the entrance requirements to the group.

Recommendation:

- 147** That the present requirement that applicants be twenty-one years of age before being licensed as ophthalmic dispensers be eliminated.

The Board of Ophthalmic Dispensers has the power to make by-laws covering its meetings and expenses, the appointment, payment and duties of teachers, examiners and inspectors, and arrangements with any university, college or school for such lectures and instruction as may be necessary.

Subject to the approval of the Lieutenant Governor in Council, the Board can make regulations prescribing a home study course; prescribing admission requirements to schools of ophthalmic dispensing, fees for examinations, licensing, certification renewal, fees and expenses for Board members; providing for the holding of licensing examinations; governing the licensing of candidates and the suspension or cancellation of licences; and defining unprofessional conduct. Amendments to the regulations are submitted through the Department of Health to the Ontario Legislature by the Lieutenant Governor in Council.

The Committee has outlined in Chapter 25 its view that only a limited number of health disciplines should continue to have self-governing powers; other groups should be included under an overall regulatory body established by the Province. We include ophthalmic dispensing in this latter category. Because of the importance of the ophthalmic dispenser in the vision care field, and in conformity with our general view of regulatory arrangements, however, we believe that ophthalmic dispensers should be licensed.

Recommendation:

- 148** That ophthalmic dispensers be licensed by the Health Disciplines Regulation Board through a Division for ophthalmic dispensers.

The Act specifies that no ophthalmic dispenser may supply an ophthalmic appliance except upon the prescription of a qualified medical practitioner or an optometrist, but he may duplicate such prescriptions.

Although only qualified personnel may fill the prescriptions of optometrists and ophthalmologists, nothing in the Ophthalmic Dispensers Act prevents either the sale of industrial goggles, sunglasses, or magnifying glasses if not sold to correct visual or muscular errors or defects, or the sale of eyeglasses by a retail merchant. The latter practice may be regulated by the Lieutenant Governor in Council, but regulations have not been passed.

Prescription goggles used for safety purposes are often obtained by mail from wholesale suppliers and prescriptions are filled by mail for such purposes. Glasses handled in this manner are not properly fitted, adjusted and checked for accuracy and may lead to visual problems or non-use of the safety eye wear. The Committee wishes to eliminate the practice of safety suppliers filling prescriptions for safety eyeglasses by persons other than licensed personnel and the mailing of such eye wear directly to the patient.

Recommendation:

149 That section 20(b) of the Ophthalmic Dispensers Act be clarified to ensure that safety eyeglasses are excepted from the supervision of a licensed ophthalmic dispenser only if they do not incorporate a prescription.

The Board of Ophthalmic Dispensers in its brief to the Committee expressed its concern with indiscriminate advertising of eyeglasses by price.²⁹ The Committee is concerned about the control of advertising for all groups in the health field, particularly by ophthalmic dispensers, and believes that the Health Disciplines Regulation Board should undertake a continuing review of advertising by ophthalmic dispensers.

Recommendation:

150 That advertising by ophthalmic dispensers should be reviewed by the Health Disciplines Regulation Board.

Voluntary Association

The Ontario Association of Dispensing Opticians was founded by a provincial charter in 1946. Its aims are to improve the professional standing of the members, to protect them against all kinds of unfair competition and practices, and

²⁹Board of Ophthalmic Dispensers, Brief to the Committee on the Healing Arts, 1967, p. 9.

to promote and sustain friendly relations with all persons engaged in dispensing ophthalmic prescriptions.

The control and management of the Association and its properties are vested in a Board of Directors consisting of nine members who serve for a period of three years. They are elected by secret ballot at the annual meeting of the members. Any regular member is eligible to vote and to be elected.

After the annual meeting, the officers of the Association — president, vice-president, secretary and treasurer — are appointed by the Board. To qualify for the appointment of the office of president, a director must have served at least one year on the Board. The vice-president, secretary and treasurer must be members of the Board. These officers are appointed for a period of one year. The Board may also appoint committees as required, such as the Nominating Committee (which consists of the past president and at least two other directors), the Education Committee and the Public Relations Committee.

There are two kinds of membership in the Association: regular membership, and associate membership. A regular member is a person who meets the qualifications and ethical standards of the Association and is licensed; associate membership is for persons who meet the qualifications and ethical standards of the Association, but may be student opticians or non-licensed workers in the optical trade in Ontario.

TABLE 12.7

Membership in the Ontario Association of Ophthalmic Dispensers, 1960-1968

1960	135 regular 90 associate
1965	178 regular 28 associate
1966	233 regular 60 associate
1967	248
1968	269

SOURCE: For 1960, 1965 and 1966 figures, Ontario Association of Ophthalmic Dispensers, reply to Questionnaire "B", Committee on the Healing Arts.
For 1967 and 1968 figures, Ontario Association of Ophthalmic Dispensers, Communication to the Committee on the Healing Arts, January 1969.

An optician must be licensed by the Board of Ophthalmic Dispensers to practise and to be a regular member of the Association. The Association has no regulatory powers, but it may make recommendations to the Board on any problems relating to Association members. The Association holds two conventions each year and also communicates with the members of the Association by newsletter. In an attempt to ensure an adequate supply of persons practising, members of the Association are encouraged to employ students taking the home study course in order to give them practical experience.

Ophthalmic Assistants

In recent years ophthalmologists and hospitals have been employing an increasing number of ophthalmic assistants, persons trained to perform certain limited functions under the supervision of an ophthalmologist. In a textbook written for ophthalmic assistants by two Toronto physicians, the role of the ophthalmic assistant is seen as follows:

... (to) provide reliable and competent eye care prior to and following regular visits to offices and clinics. The ophthalmic assistant must be familiar with procedures regarding sterility, the nature of emergency patients, and technical aspects of ophthalmology. With this knowledge the ophthalmic assistant can increase the efficiency of an office or clinic, maintain better supervision of ocular instruments and trays, and ensure that all details of the diagnostic workup and regimen are understood and carried out by the patient. Although emphasis is on the paramedical functions of the ophthalmic assistant, we recognize that in a small office, both positions may have to be carried out by the same individual.³⁰

The time-saving aspect of employing ophthalmic assistants was emphasized by the Ontario Medical Association Section on Ophthalmology, both in its brief and at its hearing with the Committee. The ophthalmic assistant can relieve the ophthalmologist of many routine tasks which underutilize his skills, and permit him to see more patients than would otherwise be possible.

Although the exact number of ophthalmic assistants in Ontario is not known, since most are trained informally, in 1966 the Ontario Medical Association estimated it to be between 250 and 300. By 1969 there were 204 members of the Association of Ophthalmic Assistants of Ontario, an association formed in 1966 under the guidance and sponsorship of the Ontario Medical Association Section on Ophthalmology. Regular members, of whom there are seventy-nine, have had two years' experience with an ophthalmologist on a preceptorship basis, while student members have had less than two years' experience and may be taking the course for ophthalmic assistants.

Training in Ontario

Until quite recently, any training received by Ontario ophthalmic assistants was obtained on the job. Under the auspices of the Ontario Medical Association Section on Ophthalmology, however, a one-year home study course was instituted in 1965. Material is sent out monthly with questions to be answered and returned. When the course is successfully completed, the ophthalmic assistant receives a certificate and, after two years' experience, becomes a member of the Association.

³⁰Harold A. Stein and Bernard J. Slatt, *The Ophthalmic Assistant*, C. V. Mosby Co., Saint Louis, 1968, p. ix.

During July and August in 1969, for the first time, a six-week academic course for ophthalmic assistants was held at Centennial College, a College of Applied Arts and Technology in Scarborough, after which the student was expected to gain one year's experience in a preceptorship program. Grade twelve is the required entrance standard, and the course is limited to thirty-five students.

Training in the United States³¹

Various training programs for ophthalmic assistants are available in the United States, including training given to servicemen in the armed forces, courses at three universities, and a home study course provided by the American Association of Ophthalmologists.

Since 1967 Baylor University, Texas, has operated an eight-week summer course, which is followed by a twelve-month preceptorship program, preferably taken in a hospital clinic. Completion of high school and sponsorship by a qualified ophthalmologist are required for entrance, although two years of College are preferred. The first five weeks are devoted to lectures in basic sciences; the remaining three are used for workshops and demonstrations.

Since 1963 the Georgetown University College of Medicine, Washington, D.C., has run a four-semester, two-year course, commencing every two years. Applicants must have completed two years of college, be registered as a practical nurse, or have two years' experience and sponsorship by a qualified ophthalmologist. No tuition is charged and each student is paid a stipend from a public health service training grant. The time is divided between formal lectures and clinical experience.

The third university to offer a training program for ophthalmic assistants is the University of Minnesota. In addition, the Massachusetts Eye and Ear Infirmary, Boston, operates a training program combining lectures and on-the-job training.

The American Association of Ophthalmology instituted a home study course in 1967, lasting from September until the following May. The Association attracted its students by sending applications and information to ophthalmologists across the country, and by May 1968, 1,904 trainees were enrolled.

Requirements for Ophthalmic Assistants

The Committee believes that the Ontario Medical Association Section on Ophthalmology rightly stresses the importance of ophthalmic assistants whose employment makes possible the reallocation of routine functions and release more of the ophthalmologists' valuable time.

In a submission to the Ontario Council of Health, September 1968, the Ontario Medical Association Section on Ophthalmology presented a long-range

³¹Information in this section taken from Bernard Blais, "The Need, Training and Utilization of Ophthalmic Assistants", *The Eye Physician*, July 1968.

view of eye care for Ontario. According to their submission, even though the ophthalmic assistant is involved only in physical procedures such as ocular photography, and not in diagnosis or prescription, the ophthalmologist can increase his work load by 40 per cent without sacrificing quality of patient care, by employing an ophthalmic assistant. This long-range view envisages the function of optometrists as limited solely to refraction, with ophthalmologists and opticians providing most eye care.

The Committee views ophthalmic assistants as important, but not as a replacement for optometrists. The assistants are important because they increase the productivity of medical specialists. Therefore, it appears highly desirable that the supply of these supporting personnel be maintained in the future and that suitable training facilities be organized. If the estimate of the Ontario Medical Association Section on Ophthalmology is correct, that there are between 250 and 300 ophthalmic assistants in Ontario, then the apparent ratio of ophthalmologists to ophthalmic assistants of 1 to 1.5 is not unreasonable. The problem then is to maintain this ratio and assure that facilities exist for a proper level of training of these personnel.

In view of the pressure which the expansion of medical training facilities puts on faculties of medicine, the latter appear reluctant to engage directly in the training of ophthalmic assistants. In a hearing with the Committee, however, the ophthalmologists representing the Ontario Medical Association stressed the need for a formalized training course rather than on-the-job training because of the amount of time necessary to instruct the assistant in basic techniques.

Potential training facilities do exist and can be expanded at the teaching hospitals affiliated with universities. We see no reason why a joint program (or programs) organized by a teaching hospital and a College of Applied Arts and Technology should not be established to meet future needs.

Chapter 13 Mental Health Personnel

The assessment of the adequacy of mental health personnel, both quantitatively and qualitatively, was one of the most important and difficult tasks which faced the Committee in its study of health services in Ontario. Important in the Committee's considerations in respect to mental health were a number of problems which, in many ways, differed from those of health services in general.

One of the most striking features is the prevalence of mental illness in any given population. According to recent findings published by the Dominion Bureau of Statistics (DBS), 12.7 per cent of all males and 11.7 per cent of all females in Canada are expected to be admitted to a psychiatric institution on at least one occasion during the remaining years of their lives. These figures present only a conservative estimate, because they exclude those who do not utilize inpatient facilities even though in need of treatment, and those who utilize other facilities such as outpatient facilities and the services of private psychiatrists.¹

A recent study of mental health personnel and services in Ontario carried out by Charles Hanly for this Committee estimated that

... approximately 20-25 per cent of Ontario's population have suffered, are suffering or will suffer from a psychiatric disorder sufficiently impairing to require treatment by a qualified professional in one or other of a number of different treatment settings.²

The greatest cause for concern is that there is a major and general shortage of all types of mental health personnel in Ontario. It will be seen in the following sections of this chapter that Ontario universities and other training institutions are not producing an adequate number of graduates to keep up with increasing demands. Formal specialized training programs in psychiatric social work and psychiatric nursing are virtually non-existent in Ontario. Our manpower supply in these areas is made up of graduates of foreign programs, unqualified staff who have received additional in-service training in psychiatric settings, and graduates of general social work and general nursing programs. As there is a shortage of manpower across all areas of social work and no excess supply of nurses, there appears to be little hope for improvement as long as the present situation is allowed to continue. Postgraduate training programs for psychiatrists and clinical psychologists also are subject to serious criticism: psychiatry departments have

¹Dominion Bureau of Statistics, *Mental Health Statistics, The Expectation of Admission to a Canadian Psychiatric Institution*, Queen's Printer, Ottawa, October 1968.

²C. Hanly, *Mental Health in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 20.

been slow in introducing psychodynamic theory and supervised psychotherapeutic practice into the psychiatric curriculum; most psychology programs have a heavy experimental bias and place little emphasis on clinical practice. The result is that many medical and psychology graduates are attracted to the United States for postgraduate training. While our Canadian programs produce approximately 100 psychiatrists a year, it has been estimated that between thirty and thirty-five Canadian physicians graduate annually from American psychiatric training programs and that most of these stay in the United States.³ Another survey has estimated a total of approximately 160 United States citizens working as psychologists in Canada, while some 240 Canadian psychologists are employed in the United States.⁴

The matter is complicated by the fact that the body of knowledge on the treatment of mental illness is very small compared to what is known of physical illness. The exploration of man's mental processes as a science within the health field is relatively young, and there is widespread and intense disagreement concerning scientific issues in the field. The major division is between the physicalist hypothesis, which postulates a direct organic determination of mental illness, and the psychodynamic hypothesis, which emphasizes the role of human interactions in the determination of personality formation and functioning. The majority of the members of Ontario mental health professions adopt an intermediate position between the two extremes, and do not restrict treatment to either physiological and pharmacological methods or psychological methods which focus special attention on the emotional interrelationships between the patient and the therapist.⁵ Nevertheless, the existence of these conflicting views within the field has an important impact on the training of mental health personnel as well as on their legal, economic and social status in the field.

Conflicts of view also breed uncertainties regarding professional roles and status, which further complicate the provision of mental health care. Effective modern psychiatric treatment, especially in institutions, consists of the application and coordination of the activities of professional persons with diverse therapeutic skills. Unfortunately, it is not easy for several new professions with overlapping skills to agree on their respective roles so that differences in concept of role exist even among the psychiatrists, clinical psychologists and psychiatric social workers themselves. These are the findings of many sociological studies of developing social relationships among the mental health professions in a psychiatric hospital. While social workers (including psychiatric social workers) are oscillating between a psychological and a sociological focus in their work, they have not clarified, to

³R. C. A. Hunter, M.D., and D. H. Frayn, M.D., "Teaching of Psychiatry: A Survey of Post-graduate Psychiatric Education in Canada, 1966-67", *Canadian Psychiatric Association Journal*, Vol. 13, No. 5, October 1968.

⁴M. H. Appley and Jean Rickwood, *Canada's Psychologists*, Report of a Survey prepared for the Scientific Secretariat (Privy Council) of Canada, on behalf of the Committee on Research Financing of the Canadian Psychological Association, 1966.

⁵C. Hanly, *op cit.*, p. 41.

themselves or to others, the exact definition of their role. The profession of psychology, less than fifty years old and deriving from an academic background, has yet to establish a clear-cut image as a practising profession.

Research on the other mental health professions is also suggestive. Studies reveal that the psychiatric nurse, trained in traditional nursing skills, does not clearly know what is expected of her in a psychiatric setting nor how to perform psychotherapeutic duties once they have been assigned to her. Other research points to an inconsistency among nurses regarding their appropriate role in mental hospitals. Finally, one set of studies of psychiatrists, nurses, and attendants, concludes that among these groups there is "wide variation in individual role performance within a given (hospital) setting—greater variation, perhaps, than is envisaged in many sociological theories".⁶

This confusion in role definition is a major cause of conflict, especially between the psychiatrist and clinical psychologist. Fortunately, the Committee has evidence to believe that this conflict exists largely on paper. In practice, reasonable levels of cooperation among the different professions is the rule in service situations. Nevertheless, these theoretical divisions do have undesirable practical consequences, intensifying professional rivalries and impairing the cooperation among these knowledgeable disciplines not only in the provision of professional services, but in such vital areas as professional training, research, the development of therapeutic techniques, and the initiation of new mental health programs. We proceed in this chapter to give an outline of the development of the various mental health disciplines, the nature and scope of their practice, their education and training programs, the manpower situation, and the legislative controls regulating their practice. The Committee has examined the problems facing each discipline, with special attention on how current demands for more competent personnel could be met to provide the best possible services for those in need.

Psychiatry

Scope of Practice

Psychiatry is a specialty of medicine. The work of the psychiatrist is limited to "the study and knowledge of diseases of the mind, primary to the mind itself, or secondary to other organic illness. His practice is in the treatment of those patients so afflicted".⁷

The nature of the psychiatrist's practice has undergone significant changes in recent decades. Prior to the Second World War, most of the psychiatrists in Ontario worked in psychiatric institutions maintained by the provincial Department of Health. With the expansion of knowledge and improvements in diagnostic

⁶William A. Rushing, *The Psychiatric Professions: Power, Conflict, and Adaptation in a Psychiatric Hospital Staff*, the University of North Carolina Press, 1964, pp. 7-8.

⁷Ontario Psychiatric Association, reply to Questionnaire "B", Committee on the Healing Arts.

and treatment methods after the war, there has been a steadily improving approach by the public to the problems of mental illness. More and more psychiatric units have been opened in general hospitals. At the same time, the strong social demand for facilities for the custodial care and treatment of severely impaired psychotics in mental institutions has given place to an increasing demand for the treatment of milder forms of mental illness, such as emotional disturbances in children, problems of maturation in adolescents and young adults, marital problems, and a wide range of neurotic illnesses. These problems require specific knowledge, techniques and skills different from those in general psychiatry. As a result, new subspecialties in child and adolescent psychiatry, family psychiatry, community psychiatry and psychotherapy are now being developed to serve these needs.

Closely aligned with these developments is the increase in the number of psychiatrists in private practice, community clinics and special services such as centres for emotionally disturbed children, forensic clinics and schools. Most psychiatrists in Ontario engage in at least three of the four predominant modes of work of psychiatrists: hospital practice, private practice, teaching and research, and administration. In the past, Ontario has utilized most of its resources in the treatment and care of psychotic patients, so that facilities to treat them are now relatively well developed. As the taboo against mental illness diminishes, more persons will be seeking treatment for the commoner and milder forms of disorders, thus exerting an increasing pressure for expansion in this sector. At present there are more psychiatrists engaged in clinical work in hospital inpatient and outpatient facilities and in clinics than in private practice. But it may be expected that more and more psychiatrists will go into private practice, which is considered to be best suited for the treatment of psychoneurotic illnesses.⁸

The Committee believes that the direction of growth in psychiatry in Ontario towards a broader field of practice in the office, in general hospitals, outpatient clinics and various social organizations is one which should be encouraged.

Manpower

There were 411 qualified psychiatrists on the list maintained by the Registrar of the College of Physicians and Surgeons of Ontario as of July 31, 1967. Of these, forty-four were non-residents of Ontario.

Table 13.1 shows the detailed geographical distribution of the 367 psychiatrists residing in Ontario. Most of these are concentrated in the metropolitan areas of Toronto, Hamilton, Kingston, London and Ottawa, which have 157, twenty-six, twenty-six, thirty-two and twenty-seven psychiatrists respectively. This leaves ninety-nine psychiatrists serving the remaining areas of Ontario. This concentration results in an unequal distribution of psychiatrists in the province, as Table 13.2 shows. The problem of maldistribution is even more serious when one considers that most of the psychiatrists who are working outside these five centres

⁸C. Hanly, *op. cit.*, pp. 86-88.

TABLE 13.1
Geographical Distribution of Psychiatrists in Ontario, 1967

Barrie	1	Niagara Falls	1	Smiths Falls	1
Belleville	1	North Bay	2	Southampton	1
Blenheim	1	Oakville	5	Stoney Creek	1
Brampton	2	Orillia	1	Sudbury	3
Brantford	6	Oshawa	1	Thornhill	1
Brockville	5	Ottawa	27	Metropolitan	
Clarksburg	2	Owen Sound	2	Toronto	157
Cobourg	2	Palmerston	1	Trenton	1
Cooksville	2	Penetanguishene	2	Waterloo	3
Cornwall	1	Peterborough	1	Welland	1
Fort William	1	Pickering	1	Whitby	3
Guelph	8	Port Arthur	5	Windsor	6
Hamilton	26	St. Catharines	5	Woodbridge	1
Kingston	26	St. Jacobs	1	Woodstock	3
Kitchener	2	St. Thomas	6		
London	32	Sarnia	3		
Newmarket	2	Sault Ste. Marie	1	GRAND TOTAL	367

SOURCE: Medical Directory, College of Physicians and Surgeons of Ontario, July 31, 1967.

TABLE 13.2
Psychiatrist:Population Ratio in Ontario, 1967

Location	Number of psychiatrists	Population	Psychiatrist:population ratio
Metropolitan			
Toronto	157	2,210,000	1:14,076
Hamilton	26	458,104	1:17,619
Kingston	26	59,917	1: 2,305
London	32	211,748	1: 6,617
Ottawa	27	505,290	1:18,714
Other areas in			
Ontario	99	3,703,741	1:37,412
Total	367	7,148,800	1:19,479

SOURCE: C. Hanly, *Mental Health in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, pp. 65-66.

are employees of provincial mental institutions operated by the Department of Health. Consequently, their services are available to the communities in which they are located only through hospitalization or through the outpatient departments of hospitals.

The psychiatric manpower situation in Ontario has shown considerable improvement in recent years. Table 13.3 indicates that in 1961, there was one psychiatrist per 26,900 population; in 1966, there was one psychiatrist per 17,500 population. Ontario also compares favourably with the rest of Canada, according to records kept by the Royal College of Physicians and Surgeons of Canada of the number of psychiatrists certified by the College.

TABLE 13.3

Comparison of Psychiatrist:Population Ratios in Ontario and in Canada, 1961 and 1966

Location	As at September 30, 1961		As at April 23, 1966	
	No.	Population ratio ¹	No.	Population ratio ²
Ontario	229	1:26,900	389	1:17,500
Canada, all provinces	540	1:33,400	898	1:21,900

¹DBS, estimated at June 21, 1961.

²DBS, estimated at January 1, 1966.

SOURCE: Royal College of Physicians and Surgeons of Canada, reply to Questionnaire "A", Committee on the Healing Arts.

The discrepancy between the 1966 ratio of one psychiatrist per 17,500 population in Ontario shown in Table 13.3 and the 1967 ratio of 1:19,479 shown in Table 13.2 is due to the fact that the 1966 figures were based on the total number of psychiatrists in the records of the Royal College of Physicians and Surgeons of Canada while the 1967 figures were based on the Register kept by the College of Physicians and Surgeons of Ontario. The figures of the Ontario College are more realistic in that they include only psychiatrists residing in the province who, to the best of the knowledge of the Registrar of the College, were in active practice at the time the Register was compiled, while the Royal College figures include some psychiatrists who are no longer practising in Ontario, because of death, retirement or emigration.⁹

Although Ontario has the best psychiatrist:population ratio in Canada, the present manpower situation is far from satisfactory. The problem is one not only of unequal geographical distribution but also of manpower shortage. Since there is

⁹Royal College of Physicians and Surgeons of Canada, reply to Questionnaire "A", Committee on the Healing Arts.

no clear-cut index of the optimal ratio of psychiatrist to population, no precise estimate of "shortages" can be made. The ratio of one psychiatrist per 10,000 population has been set by the Canadian Psychiatric Association (CPA) as a realistic figure for the provision of adequate care.¹⁰ This would imply an immediate need for almost double the number of psychiatrists available now. A considerably lower figure of one psychiatrist per 15,000 population is also often used as a goal.¹¹ However, allowing for population increase, even this lower ratio would call for doubling the number of Ontario psychiatrists over the next ten years.

At present, Ontario is training approximately 100 psychiatric residents in the four-year postgraduate programs directed by the University of Toronto, the University of Western Ontario, Queen's University and the University of Ottawa. This would mean that about twenty-five trainees will be sitting for the Royal College examinations in any one year to become qualified psychiatrists in Ontario.¹² To this number may be added the repeaters, late triers and graduates from foreign training schemes, thus bringing the number of new psychiatrists completing training up to about forty per year. However, it has been estimated that about half of these newly qualified psychiatrists simply balance the losses through death, retirement or emigration, while twenty will be needed each year, for the next five years, for each of the areas of teaching, child psychiatry and forensic psychiatry.¹³ Thus, any one of these subspecialties could absorb all of the additional psychiatrists that will likely commence practice in the province over the next five years, leaving no surplus for clinical practice in institutions and in private practice. This obviously will not happen, however, as it has been predicted that an increasing number of psychiatrists will be spending more time in private practice. The result is that, five years from now, the shortages in these special areas of practice as well as in psychiatric institutions will remain as acute as now.

At present, the thirty-three public mental institutions operated by the Ontario Department of Health are the largest single group of employers of psychiatrists. Together with seven private psychiatric hospitals, these institutions employed a total of 131 full-time and forty part-time qualified psychiatrists out of the total of 367 psychiatrists in the province in 1967.¹⁴ However, these public institutions were still understaffed. A survey carried out in the same year listed twenty-one vacancies for psychiatrists needed to maintain existing services.¹⁵ More would be needed if services were to be expanded or if the psychiatrist:patient ratio were to be raised.

There will be also an increased need for psychiatrists as the demand for the treatment and care of the milder forms of mental illnesses increases and as the sub-

¹⁰Canadian Psychiatric Association, Brief to the Royal Commission on Health Services, May 1962, Appendix 13.

¹¹F. C. Rhodes Chalke, M.D., M.Sc. (Med.), F.A.P.A., "'Growing Pains' in Psychiatric Services", *Ontario Medical Review*, September 1966.

¹²R. C. A. Hunter and D. H. Frayn, *op. cit.*

¹³F. C. Rhodes Chalke, *op. cit.*

¹⁴DBS, *Mental Health Statistics*, Vol. III, Queen's Printer, Ottawa, 1967.

¹⁵C. Hanly, *op. cit.*, p. 68.

specialties of child psychiatry, adolescent psychiatry, family psychiatry, community psychiatry and forensic psychiatry are better developed. To specialists needed in these service areas may also be added the researchers, teachers and administrators who have to come from the same manpower pool.

There can be no doubt that a considerable unmet demand exists for the services of psychiatrists as well as other mental health practitioners. The number of unfilled vacancies in existing institutions, the need for more mental health facilities of various kinds, the incidence of mental illness in the population, and the growing emphasis on social and behavioural medicine all lead to the conclusion that the shortage of personnel in this area is acute. While much can be done by non-medical mental health practitioners, the key role of the psychiatrist makes it apparent that his services will continue to be in short supply in the foreseeable future. Thus, we believe that special attention must be given to the training of increased numbers of psychiatrists.

Recommendation:

151 That a high priority be given to the training of additional psychiatrists in Ontario.

Education

Psychiatrists have shared with their colleagues in the medical profession a common core of undergraduate education and a year spent in junior rotating internship in a general hospital. Specialized psychiatric training is undertaken at the postgraduate level and culminates in an examination conducted by the Royal College of Physicians and Surgeons of Canada. To be eligible for sitting the Royal College examination, a candidate must have completed four years of postgraduate training in addition to the junior internship. The trend towards increasing involvement of the universities in postgraduate medical education is relatively far advanced in the case of psychiatry; the Royal College requires that "the period of training and study in psychiatry required in Canada for eligibility for either the fellowship or certification examination must be organized under university auspices to achieve an overall psychiatric experience".¹⁶ At least two of the years of resident training must be spent with the resident involved in an intensive learning experience in an organized training program of a university department of psychiatry. The additional two years of resident training, also under university direction, provide a wider choice for the trainee.

The responsibility for training psychiatrists lies with the departments of psychiatry in Ontario's five university medical schools (Ottawa, Western, Queen's, Toronto and McMaster) and the teaching hospitals in which students take their

¹⁶Regulations and Requirements of Graduate Training Relating to the Examinations of the Royal College of Physicians and Surgeons of Canada, Medicine and Medical Specialties, April 1967, p. 28.

residency training. The first formal program for the training of psychiatrists in Canada was established in 1937 at the University of Toronto. Since then, a number of changes have been made to improve the program. The number of years of training has been increased from two to four. University departments, as we have pointed out earlier, have gained greater influence over the quality and direction of psychiatric training. The emphasis on anatomy, biochemistry and physiology in the undergraduate curriculum is slowly being reduced to give place to an increase in the content of theoretical and practical psychodynamics. The most significant recent development has been the establishment of a new department of psychiatry at McMaster University. The psychiatric residency program at McMaster involves, along with the complete range of hospital experience, comprehensive training in psychodynamic psychiatry, directly planned and organized by the department of psychiatry.¹⁷

These latter changes are associated with the growing acceptance of psychiatry in the basic medical course and the increasing awareness of the emotional components in illness, both physical and mental. Even in other medical schools where the program has been too structured to allow for sudden changes, the curriculum has been altered to allow the student throughout his undergraduate training to have more opportunity to utilize elective time in fields such as research and other special projects. As a result, more medical graduates may be expected to go into specialist training in the field of psychiatry.

The Royal College approves certain hospitals for "advanced graduate training"—that is, training beyond the level of the junior internship. One of the requirements of the Royal College is that "the training program must also include at least six months and preferably one year in a hospital providing an opportunity for the study of the comprehensive care of psychotic patients. . . ."¹⁸ Since the Ontario Hospitals are the major centres for the treatment of psychotic patients, the effect of the regulation is to make an Ontario Hospital residency of not less than six months practically mandatory. In fact, the mental hospitals were the major training centres before the development of psychiatric units in general hospitals. The mental hospital residency has proved to be inadequate, chiefly because it provides only a limited learning experience to the resident. During the past two years, an increasing share of the burden of psychiatric residency training is being taken over by other treatment facilities such as psychiatric units of general hospitals, specialized psychiatric hospitals for children and outpatient treatment facilities.

Of the eighteen hospitals in Ontario approved by the Royal College for advanced graduate training in psychiatry in March 1966, six were Ontario Hospitals.¹⁹ By July 1968, eleven new training institutions had been added to the list.

¹⁷C. Hanly, *op. cit.*, p. 75.

¹⁸Regulations and Requirements of Graduate Training Relating to the Examinations of the Royal College of Physicians and Surgeons of Canada, *op. cit.*

¹⁹"Canadian Hospitals Approved for Advanced Graduate Training", *Canadian Medical Association Journal*, Vol. 94, April 2, 1966, pp. 748-756.

These include six psychiatric units of general hospitals, two hospitals for emotionally disturbed children, one research and treatment centre for alcohol and drug addicts, one outpatient clinic, and one children and family treatment centre.²⁰

The Royal College confers two kinds of specialist qualifications: the Fellowship and Certification, the difference being in the standard of examinations required. Candidates who are successful in the Fellowship examinations are granted automatically the appropriate specialist certificate.²¹ Both levels of qualification are, however, officially recognized by the licensing body as well as by the voluntary professional association in Ontario. A list of qualified psychiatrists would, therefore, include both Fellows and Certificants.

There are no specified requirements concerning continuing education established by either the licensing body (the College of Physicians and Surgeons of Ontario), the qualifying body (the Royal College), or the voluntary association (the Ontario Psychiatric Association). Some efforts in this direction have been made on a voluntary basis by the Royal College and the Ontario Psychiatric Association, usually through the presentation of professional papers at annual general meetings, as well as through the annual and periodic regional meetings of the Canadian Psychiatric Association and the Canadian Mental Health Association.

Regulation

Since all psychiatrists are licensed medical practitioners in the province of Ontario, matters such as licensure and discipline covering the practice of their profession are under the same legislative controls and code of ethics which regulate the practice of medicine and all its specialties. Section 62 of the Medical Act authorizes the College of Physicians and Surgeons of Ontario to be the specialist-recognizing body in the province. Pursuant to this authorization, the College recognized as specialists only those persons holding a certificate of specialization of the Royal College of Physicians and Surgeons of Canada.²²

In practice, unless a physician wishes to be officially recognized as a qualified specialist by the Ontario College, a Royal College qualification is not necessary for him to practise, and there is nothing in the law to prevent him from practising, any branch of medicine. In fact, a study carried out by Hanly shows that the practice of psychiatry is carried on by considerable numbers of general practitioners in particular and, to a lesser extent, also by other non-psychiatric specialists.²³

²⁰Graduate Training Programs Approved by the Royal College of Physicians and Surgeons of Canada, as at July 1, 1968, *Canadian Hospital Directory*, 1969, Canadian Hospital Association.

²¹For a fuller discussion of the Fellowship and Certification examination procedure, see Chapter 8, pp. 74-78 and p. 91.

²²*Warning Notice* issued by the Council of the College of Physicians and Surgeons of Ontario, 1966, Regulations Relating to Recognition, Classification and Designation of Specialists made pursuant to Section 62 of the Medical Act.

²³C. Hanly, *op. cit.*, pp. 108-111.

The Committee notes that the present powers given to the College of Physicians and Surgeons of Ontario under the Medical Act allow the College to establish equivalent standards for specialty qualifications granted outside Canada, but that to date it has restricted recognition to the Royal College certification and fellowships. Because of this restriction, a medical specialist who has received part or all his training outside Ontario may be deterred from entering into practice in Ontario in three ways:

- 1) If he has received his undergraduate medical training outside Ontario, he may not be able to practise medicine or surgery or any of their branches in the province without going through the procedures of qualifying for and obtaining a licence to practise medicine, although he has obtained his specialist certificate from the Royal College of Physicians and Surgeons of Canada.
- 2) If he has received his undergraduate training in an Ontario university but has obtained his specialist certificate from an institute other than the Royal College, he may practise medicine and surgery in Ontario but his specialist qualifications may not be recognized.
- 3) If he has received his undergraduate training outside Ontario and his specialist certificate has been granted by a body other than the Royal College, he will have to meet very stringent requirements before he is allowed to practise at all in Ontario.

In all three cases the psychiatrist will have to pass further examinations and/or take further training in Ontario before he is officially recognized as a fully registered specialist in the province.

The Committee is aware of the importance of maintaining a high standard of medical practice in the province and of the need for stringent requirements to screen out incompetent and poorly prepared practitioners. However, the Committee feels that opening the door to specialists of equivalent status elsewhere could result in a greater inflow of psychiatrists to Ontario.

Recommendation:

- 152** That the College of Physicians and Surgeons of Ontario be urged to establish which specific specialty qualifications granted outside Canada are equivalent to those granted by the Royal College of Physicians and Surgeons of Canada and that physicians with such appropriate specialty qualifications, provided they are appropriately designated as specialists in the jurisdiction in which they should be eligible to be so designated, should be included without further training or examination, on the Specialist Register of the College of Physicians and Surgeons of Ontario.

Voluntary Association

The voluntary association²⁴ of psychiatrists in Ontario was founded in 1920 as the Ontario Neuropsychiatric Association and was reorganized as the Ontario Psychiatric Association in 1956, the year it obtained its charter from the Provincial Secretary. The authoritative body of the Association is the Board of Directors or Governors which is also the Council. Broadly speaking, the objects of the Association are to encourage communication and exchange of scientific information among psychiatrists in Ontario, to promote their professional welfare and usefulness; and to represent its members in their dealings with other organizations and bodies with which psychiatrists in Ontario from time to time may have relationships.

The Association has six different categories in its membership designated as members, junior members, associate members, affiliate members, life members and honorary members. While only qualified psychiatrists may be voting members or full members of the Association, the other categories embrace a wide variety of mental health personnel. These include physicians who are interested in or are actually engaged in psychiatric work, and persons who occupy senior positions in nursing, psychology, social work, occupational therapy or physiotherapy, or any similar occupations closely related to psychiatry.

The Association has no formal powers in matters regarding the licensing and regulation of the practice of psychiatry, the setting up of psychiatric fee schedules, or the establishment and control of medical training standards. It does, however, act in an advisory capacity in these matters. The most notable effort made by the Association in the promotion of psychiatry was the initiation of a program in 1965 which consists of a series of weekly seminars in the major centres across the province in cooperation with the College of Family Physicians of Canada, formerly the College of General Practice of Canada. These seminars were open to any general practitioner who wished to improve his knowledge in the field of psychiatry and were conducted in an attempt to enable general practitioners to handle a greater number of the less intricate psychiatric cases they find in their practice. Members of the Ontario Psychiatric Association acted as teachers or instructors. Unfortunately, this program appears to be faltering, not for lack of interest among general practitioners but for lack of stable financial and organizational support from government. Like so many voluntary efforts of its kind, the program also suffered when the individual chiefly responsible for providing the original leadership and drive withdrew from the program.

The Ontario Psychiatric Association maintains a liaison with the Canadian Psychiatric Association, the Ontario Medical Association, the Department of Health of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario Psychological Association, the Ontario Association of Professional Social Workers, the Ontario Association of Occupational Therapists and the Registered

²⁴Ontario Psychiatric Association, Brief to the Committee on the Healing Arts, 1967, pp. 7-9, 12-14; and reply to Questionnaire "B", Committee on the Healing Arts.

Nurses' Association of Ontario. The Association also maintains a somewhat loose and informal relationship with the American Psychiatric Association through a number of its members who are also members or Fellows of the American Psychiatric Association.

General Practitioners

Involvement in Mental Health

General practitioners in Ontario handle more psychiatric problems than do any other type of physician. This is indicated by a study carried out by Hanly of the diagnostic and treatment data collected by the Ontario Medical Services Insurance Division of the Department of Health over a period of six months in 1967.²⁵ The study compares the number of patients with psychiatric diagnosis seen and the number of services rendered to them by general practitioners in private practice to the number of patients seen and services rendered by psychiatrists and by selected non-psychiatric specialists (in general surgery, internal medicine, neurology, obstetrics and gynaecology). Only those subscribers who were enrolled in the plan for the entire period of six months were included in the study. The results show that during this period, in the case of short-term treatment, together the four non-psychiatric specialties mentioned above gave approximately 7,200 services to 4,100 patients; psychiatrists gave 31,600 services to 5,500 patients; and general practitioners gave 91,200 services to 38,900 patients. As to long-term intensive treatment, the study shows that general practitioners in private practice treated more than three times as many patients receiving multi-service treatments as psychiatrists in private practice. In the six-month period, each patient was seen an average of twenty-three times by the general practitioner as compared to sixteen times by the psychiatrist. The contributions of other specialists were small in comparison with either general practice or psychiatry. All this clearly suggests that general practice is carrying the major volume of medicine's contribution, outside Ontario hospitals, to mental health in the province.

Several considerations point to a continuing key role for the family physician, usually a general practitioner but possibly an internist, paediatrician or other medical specialist, in the provision of mental health services. Advances in therapeutic methods, particularly in chemotherapy, have made it possible to treat a wider range of illness than before and a larger number of patients on an ambulatory basis through outpatient clinics and physicians' offices. It is apparent in the face of the shortage of psychiatrists documented above that another source of trained medical personnel must be tapped to provide those mental health services requiring medical expertise, and the family physician, with his opportunities for long-term and intimate contact with the patient and the high psychological content of his practice, is very favourably situated for this purpose. At present, however, the general prac-

²⁵C. Hanly, *op. cit.*, pp. 108-111.

itioner is attempting to provide a wide range of mental health services on the basis of inadequate psychiatric training. If his potential contribution to the mental health system is to be realized, his role must be more specifically defined and his training must equip him to fulfil that role. In recent years, a number of attempts have been made by psychiatrists, by general practitioners, and by other professional and lay groups, to delineate the role of the family physician in mental health. The official position of most groups of psychiatrists has been to recognize that their own numbers will never be sufficient to provide services to individuals on the scale required, and that, as one psychiatrist stated before a World Health Organization conference in Geneva in 1963, "from the psychiatrist's standpoint there is no question that a category of physician covering the same field of work as the general practitioner is needed now and in the future".²⁶ In taking this stand, psychiatrists have pointed to the need for better psychiatric education for the family physician and for cooperation between the psychiatrist and the family physician. Groups of family physicians, for their part, have enthusiastically promoted the importance of the family physician in mental health. The College of Family Physicians of Canada has attempted both to define the psychiatric role of this type of practitioner, and to encourage the development of programs to provide him with psychiatric education. In its submission to the Alberta Mental Health Study in 1968, the Alberta Chapter of the College of Family Physicians of Canada outlined the family physician's role in mental health as follows:

- 1) Preventive.
- 2) Educative.
- 3) Diagnostic.
- 4) Continuous care of less seriously disabled patients and their maintenance in the community as active members of the community.
- 5) Continuous care of those in nursing homes or chronic care institutions and continuing care of those who are at home under the care of relatives.
- 6) The administrative care of those who have been referred for private psychiatric care in cooperation with the psychiatrists.
- 7) Joint care of those being shared with private psychiatrists in their management.
- 8) The acute care of those in general wards admitted by the family physician.
- 9) The care of those in selected psychiatric wards attached to major general hospitals.

²⁶See Chapter 30, p. 196.

- 10) Liaison with the community services in the field of mental health care; for example, guidance clinics, the welfare department of the city or province, hospital social workers and nurses, public health nurses and the Victorian Order of Nurses.²⁷

Pilot projects at the University of Saskatchewan, in which the general practitioner performs a first contact and the psychiatrist a consultative role, have indicated the benefits to be reaped from cooperation between the two types of medical personnel.²⁸ However, despite this official willingness and the success of initial pilot projects, there remain practical barriers to general practitioner-psychiatric cooperation: notably, the shortage of both types of personnel (and especially that of psychiatrists), the tendency of the latter to locate almost exclusively in the larger urban areas, and the one to one patient-psychiatrist treatment approach in which many psychiatrists were trained, which may make them uncomfortable and decrease their effectiveness in a consultant role.²⁹ The family physician, then, not only must function in cooperation with the psychiatrist; he must treat a variety of minor mental disorders independently, or through the marshalling of other community mental health resources. The distinctive role of the family physician in integrating the various health services received by his patient and in providing continuous care extends to mental health services as well, and his training should be directed towards this end.³⁰

Psychiatric Training

Until very recently, programs of medical education have provided insufficient basic knowledge and practical training to prepare medical students to deal adequately with mental disorders. Medical educators are increasingly aware of the problem, and a number of remedial steps have been taken. The Committee expects that future progress may include the following avenues of change.

Continuing Education

One way of helping physicians already in practice is to provide them with opportunities for supplementary psychiatric education. However, a number of obstacles at once present themselves. As these supplementary training programs are voluntary, attendance by general practitioners will have to depend on the amount of interest they have in this field and on the availability of time. Hanly's survey of a random sample of 273 general practitioners in Ontario shows that of these, only forty-four (16 per cent) had received or were receiving some form of supple-

²⁷W. R. N. Blair, Ph.D., *Mental Health in Alberta*, A report on the Alberta Mental Health Study, 1968, Executive Council, Government of Alberta, Edmonton, Alberta, 1969.

²⁸D. G. McKerracher et al., "General Practice in Psychiatry: Two Canadian Experiments", *The Lancet*, November 13, 1965, pp. 1005-1007.

²⁹W. R. N. Blair, *op cit.*, p. 142.

³⁰For further discussion, see Chapter 30.

mentary graduate education in psychiatry.³¹ Another study, carried out earlier by Kenneth F. Clute, shows that of forty-four Ontario general practitioners surveyed, only three (6.8 per cent) have shown particular interest in the mental health field.³² Another source of difficulty in organizing voluntary programs is that their survival depends both on the availability of financial and organizational support from a stable source, and on the initiative and drive of individuals involved in the organization. The fate of the program sponsored by the Ontario Psychiatric Association and the College of Family Physicians, which we have described earlier, is a good example.

In other parts of this Report, the Committee has recommended that programs for ensuring continuing competence be developed for most of the groups in the health field.³³

Recommendation:

- 153** That continuing education programs for general practitioners should place special emphasis on psychiatric treatment in order that general practitioners may be better trained and have a better understanding of the diagnosis and treatment of mental illness.

Undergraduate and Postgraduate Training

A number of important changes have recently been introduced in some medical schools to improve and expand the psychiatric and behavioural science content of the undergraduate medical curriculum. The most promising signs are shown in the new medical school at McMaster University where a graduate program in family medicine is being operated under the aegis of a separate academic department. The concepts and training program at McMaster will be described in greater detail in Chapter 30. This program is aimed at producing a new "generalist" or "family physician" who will replace the old general practitioner. The family physician will be trained, both at the undergraduate and graduate levels, to provide comprehensive health care in meeting community medical needs. There will be a greater emphasis on the mental factors in prevention, diagnosis and treatment of illness. Psychiatry will be presented in a continuing program throughout the course, rather than as an isolated block of training. Two features of the McMaster program are particularly well adapted to the production of a physician to perform the mental health role sketched above. In the first place, the student is trained in the context of a "health team" and is hence alerted to the potential contributions of other professional colleagues to an integrated treatment plan. Second, the program emphasizes community medicine and trains the physician to conceive of his role in relation to the general and mental health services of the

³¹C. Hanly, *op. cit.*, p. 114, Table 5.8.

³²K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963, p. 234.

³³See Chapters 25 and 26 for general discussion of this matter.

community. McMaster admitted its first undergraduate students in September 1969. Training at the postgraduate level in family practice started in 1966. The postgraduate courses are of three years' duration and lead to certification in family practice by the College of Family Physicians of Canada.

A shift in emphasis in the undergraduate medical curriculum is also taking place in the more established medical schools, where the four major clinical subjects of surgery, internal medicine, obstetrics and gynaecology, and paediatrics have, until recently, dominated the traditional curriculum. More attention is now focused on the social and preventive aspects of medical care. The Committee feels, in the face of the considerations outlined above concerning the role of the family physician in mental health, that this new "generalist" should become a more important and better-trained source of psychiatric diagnosis and management, and that appropriate changes in the undergraduate curriculum with more emphasis on psychiatry should be made. Appropriate training in psychiatry in any postgraduate program taken by these family practitioners also should be given.

Recommendation:

- 154** That the psychiatric content of medical education and the education of the new "general physician" be expanded so that first-line medical practitioners can play larger and more effective roles in mental health care.

Psychoanalysts

Definition

"Psychoanalysis" is an exploratory method devised by Sigmund Freud in the 1890's for observing the underlying and determining psychological processes of the human mind. The use of the term is now broadened to include 1) the therapeutic method, 2) the psychological theory and 3) the research techniques which have evolved from Freud's discoveries.³⁴

Manpower

There were nineteen psychoanalysts in Ontario in 1967. The rate of increase has accelerated sharply in recent years, partly because of the appointment of psychoanalysts as chairmen of the departments of psychiatry at Toronto, Queen's and McMaster Universities, which resulted in the return of a Canadian psychoanalyst from the United States and attracted four psychoanalysts from Quebec.

Of the nineteen psychoanalysts, thirteen were located in Toronto, one in Kingston, one in Ottawa and four in Hamilton. Approximately thirteen or fourteen could be described as being principally engaged in private therapeutic practice.

³⁴William C. Menninger, M.D., *Psychiatry, Its Evolution and Present Status*, Cornell University Press, Ithaca, N.Y., p. 51.

Three were full-time teachers and administrators, being chairmen of the departments of psychiatry at the universities mentioned above. The remainder spent part of their time in clinics and hospitals and part in private practice.

It has been estimated that there is a need for approximately 100 psychoanalysts in Ontario for therapeutic practice.³⁵ To these may be added those who are needed for research, teaching and administration. In 1967, the Canadian Psychoanalytic Society had a total of fifty-nine members.³⁶ Therefore, it appears that Ontario's present prospects of approaching that goal are slight.

Training

Psychoanalytic training is, at present, a completely private matter legally, institutionally and economically. It is maintained and developed by the Canadian Institute of Psychoanalysis through its Training Committee, which is also responsible for the selection of students. The only centre for psychoanalytic training in Canada has been Montreal. However, new training programs in Toronto and Hamilton began in the autumn of 1969.

Psychoanalysis is an interdisciplinary profession in Ontario. While the Institute reserves the right to accept for training candidates with exceptional gifts beyond formal academic standards, admission is usually restricted to candidates who hold a degree in medicine or in a field such as psychology, education, nursing, sociology, or humanities, and who, by work in their field, have shown indications of developing an increasing interest in human relationships.

Psychoanalytic training consists of 1) lectures and seminars in the practice, theory and history of psychoanalysis; 2) personal analysis; and 3) supervised analysis of three patients. The lectures and seminars are spread over a period of four consecutive years. The student is subject to personal analysis during the first year or so and is usually advised to begin analysis of patients under supervision sometime during the second year. Patients to be treated under supervision are selected and allocated by the Treatment Service of the Institute. The selection of training and supervising analysis is left to the student's choice and is done on a contractual basis between the student and the analyst.

The entire cost of training, which runs from \$20,000 to \$30,000, is borne by the student. This amount covers the administrative and supervision costs.

Scope of Psychoanalysis

It appears to be a generally accepted view among psychoanalysts themselves that psychoanalytic treatment is best suited for severe psychoneurotic disorders. Psychotic illnesses, for the most part, are not benefited substantially and mild neurotic disorders can be helped by less intensive and less time-consuming

³⁵C. Hanly, *op. cit.*, p. 123.

³⁶Canadian Psychoanalytic Society, Secretary's Report: 1966-1967.

psychotherapy or counselling, depending on whether the problem is essentially psychogenetic or situational.

Psychoanalysis also contributes to mental health in two other ways. First, it provides an essential component of the theoretical foundations of all aspects of psychological medicine. In consequence, it is important in teaching in all of the mental health professions. Second, it provides a scientific technique for making observations by means of which further theoretical and practical knowledge can be gained.

Many psychoanalysts feel that two situations exist in Ontario which have restricted the growth of the profession in the province. The first is the lack of public financial support for their training programs, which are extremely expensive and therefore out of reach of many potential students. The second relates especially to non-medical analysts. Under the present Ontario Health Services Insurance Plan, psychoanalytic treatments are insured only indirectly under the category of psychotherapy. The amount of insurance coverage is based, not on the training qualifications and the nature of the service, but on the professional classification of the practitioner. If the practitioner is a specialist in psychiatry, his psychoanalytic treatments are insured at the specialist rate; if the practitioner is a physician but not a psychiatrist, his psychoanalytic treatments are insured at the general practitioner's rate, which is less; if the practitioner is not a physician, his psychoanalytic treatments are not covered at all.³⁷

The Committee does not feel itself equipped to make an informed judgment concerning the magnitude of the role that psychoanalysis should play, and whether or not there should be substantial public support to expand facilities for training of psychoanalysts and for the financing of psychoanalysis treatment. This is mainly because of the fact that psychoanalysis is a very expensive form of treatment, both in terms of the training costs involved for those administering the treatment and in terms of the cost of treatment time for each individual case. Furthermore, opinion is still divided as to the efficacy of psychoanalysis as a form of treatment for mental illnesses. The Committee believes that it would be necessary to obtain the technical judgment of a body of professionals in the mental health field, including psychiatrists, before government could make an appropriate decision on this matter. Any decision with regard to putting more resources into the support of psychoanalysis made in the light of the judgment that comes from these professionals should take into consideration the real costs involved, in terms of both time and training as they relate to services rendered.

Regulation

There is no legislation in Ontario which governs the practice of psychoanalysis. The Canadian Psychoanalytic Society acquired the responsibility of regulating the

³⁷ C. Hanly, *op. cit.*, p. 134.

practice and standards of psychoanalysis in Canada through its affiliation with the International Psychoanalytical Association. The basis of this responsibility and prerogative is the voluntary recognition of peer authority rather than law. Membership in the Canadian Psychoanalytic Society is therefore not mandatory for the practice of psychoanalysis. The only form of regulation which the Society is in a position to maintain, besides the regulation and control of its own members, is to require all persons who wish to hold the position of training analyst within the Canadian Institute of Psychoanalysis to be members of the Society.

At present, the Canadian Institute of Psychoanalysis plays a very important part in maintaining professional ethics and discipline. The Institute requires all students "to sign an Obligation not to call themselves or permit themselves to be advertised as being psychoanalysts until they have completed the course of training to the satisfaction of the Training Committee. Before a non-medical person is accepted for training he is required to pledge himself never to, nor claim himself to be competent to, diagnose the nature of a person's illness or to advise treatment by psychoanalysis; and following election to membership to treat only those patients by psychoanalysis who are referred to him for psychoanalytic treatment by a licensed medical practitioner, with whom, or with whose successor, he promises to cooperate during the duration of psychoanalytic treatment".³⁸ The Institute, through its Committee on Ethics, also has the right to impose on its members "any reasonable disciplinary sanction, including reprimand, suspension and expulsion from the Institute".³⁹

However, the source of danger to public safety in the absence of legislative controls lies mainly with those who are not regulated by any professional bodies. As there is considerable confusion in the public mind concerning psychoanalytic practice and psychoanalytic practitioners, the Committee is of the opinion that there should be legislative provisions for the registration of psychoanalysts and control of the use of the term "psychoanalysis". In making its recommendation for the introduction of a Psychoanalysts Certification Act, the Committee has taken the following circumstances into consideration:

- 1) Psychoanalysts are a mixed group including both psychiatrists and non-medical personnel; this makes it difficult for the public to assess their qualifications.
- 2) There are no centres affiliated with universities that teach psychoanalysis.
- 3) There is still uncertainty among professionals regarding the therapeutic benefits and the extent of applicability of psychoanalysis as a therapeutic tool.

³⁸Canadian Institute of Psychoanalysis, Training Program, 1963, Section 6.

³⁹Charter and By-Laws of the Canadian Institute of Psychoanalysis, By-Law 204.

Recommendations:

- 155** That a Psychoanalysts Certification Act be enacted to establish a Psychoanalysts Certification Board and to prohibit a person from representing himself to be a psychoanalyst unless he holds a certificate of registration issued by a Psychoanalysts Certification Board. No exceptions should be made to this restriction. Such an Act should be similar in form to that of the Psychologists Registration Act. The Act should permit a psychoanalyst who is not a medical practitioner to take patients directly, but where a patient has not been referred by a qualified medical practitioner, the psychoanalyst must arrange for a medical examination to ensure that the problem is not physical or organic in nature before treating the patient.
- 156** That the members of the Psychoanalysts Certification Board should, as in the case of other professional regulatory bodies, be elected from among the registrants with representation from the Department of Health and significant lay representation included on the Board. An initial Board, however, should be appointed by the Lieutenant Governor in Council for an interim period.
- 157** That the education of psychoanalysts should, as soon as possible, be brought within the purview of a recognized educational institution and that, when feasible, the control of education should be removed from the regulatory body.

Clinical Psychologists

History

Psychology emerged as a scholarly discipline in the 1830's within university departments of philosophy. During its first hundred years, psychology was mainly occupied with the teaching of knowledge about human behaviour. Because of its close links with philosophy rather than with natural science, research in psychology was at first rather intuitive, impressionistic and speculative. From the experimental investigation of behaviour in animals and humans, with an emphasis on normal rather than pathological behaviour, there developed a wide range of practical applications of psychology to education, industry and mental health. By the 1930's, this development of psychology as a "service" profession resulted in the existence of two groups of psychologists: the experimental and research-oriented university psychologists who are concerned with the development and teaching of knowledge about human behaviour, and the applied psychologists who are concerned with the application of such knowledge to produce the most effective development of human potential and the alleviation of human disability arising from mental, emotional or physical causes.

World War II accelerated this trend by attracting a large number of university staff into the armed services where they worked as applied psychologists. Postwar

demands for psychology services, particularly in the clinical area, did not abate. The training of applied psychologists became a subject of controversy between the two camps of experimentalists and service professionals, and a number of meetings were organized to discuss this question as well as the future of psychology as a service discipline. Two such conferences were held in Canada: the Opinicon Conference in 1960 and the Couchiching Conference in 1965. Despite these discussions, there is still to be found among psychologists a considerable degree of uncertainty and disagreement concerning the directions that the development of applied psychology should take.

Nor does existing legislation covering the practice of psychology provide any guideline or shed any light on the areas of competence of qualified persons. The Psychologists Registration Act,⁴⁰ which was enacted in 1960, was the result of discussions held between the Ontario Psychological Association and the College of Physicians and Surgeons of Ontario, which were aimed at providing some means to enable medical practitioners to identify qualified psychologists.⁴¹ Besides setting the requirements for registration, the Act prohibits registered psychologists from treating any type of mental disorder for a fee or other remuneration except on the request of, or in association with, a duly qualified medical practitioner.⁴²

Manpower

There were 581 psychologists on the Register kept by the Ontario Board of Examiners in Psychology in November 1968. About half of this number were located in Toronto while most of the remainder were located in the larger urban and university centres such as Ottawa, London, Hamilton and Waterloo. Table 13.4 shows the number of registered psychologists in Ontario from 1964 to 1968. It will be seen that the rate of increase in the number of psychologists dropped sharply after 1966. This is due to the expiry on June 11, 1966 of the "grandfather clause" in the Psychologists' Registration Act.⁴³ The academic qualification has since been raised to the completion of the doctoral program in psychology. Only fifteen psychologists were added to the Register in 1967, and nine in 1968.

As there are no separate registers for psychologists specializing or working in different fields, it is not known how many of the above registrants are working in clinical settings. However, a study of the location of psychologists at the time of registration in 1966 shows that 238 of the 557 psychologists were located principally in clinical settings with 172 in hospitals and clinics, fifteen in rehabilitation agencies, twenty-six in private practice and another twenty-six in social agencies.⁴⁴

⁴⁰R.S.O. 1960, c. 316.

⁴¹Ontario Psychological Association in cooperation with the Ontario Board of Examiners in Psychology and the Canadian Psychological Association, Brief to the Committee on the Healing Arts, 1966, p. 11.

⁴²R.S.O. 1960, c. 316, s. 12.

⁴³R.S.O. 1960, c. 316, s. 7, sub. 2.

⁴⁴Ontario Psychological Association, Brief to the Committee on the Healing Arts, 1966, p. 4.

TABLE 13.4
Number of Registered Psychologists, Ontario, 1964-1968

Date	Male	Female	Total
June 1, 1964	174	98	272
June 1, 1965	202	124	326
June 1, 1966	349	208	557
June 1, 1967	356	216	572
June 1, 1968	367	214	581

SOURCE: The Registrar, Ontario Board of Examiners in Psychology, November 1968.

TABLE 13.5
Number of Clinical Psychological Personnel Employed in Hospitals and Clinics, Ontario, 1966

Location	Ph.D.			M.A.			Other		
	Full time	Part time	Total	Full time	Part time	Total	Full time	Part time	Total
Psychiatric hospitals	21	16	37	53	6	59	37	4	41
Psychiatric units of general hospitals	4	6	10	12	9	21	3	5	8
Clinics and outpatient departments	16	16	32	59	36	95	25	28	53
Total	41	38	79	124	51	175	65	37	102

SOURCE: DBS, *Mental Health Statistics*, Vol. III, Queen's Printer, Ottawa, 1966.

Since employees of the Government of Canada, the Government of Ontario and universities are exempted from registration requirements, these figures do not represent all those who are in the clinical field. Table 13.5 shows that Ontario has a much bigger psychology manpower force in hospitals and clinics than the registration figures show. The hospitals and clinics in Ontario together employed 230 full-time and 126 part-time clinical psychologists in 1966.

The figures point to the high percentage of psychologists who have secondary employment besides their regular full-time work. A recent survey of 177 registered psychologists in Ontario found that 55.4 per cent of the respondents hold secondary employment, while a significant number have a third or even a fourth job.⁴⁵ The result is that many psychologists have a longer than usual work week. The reason given by the respondents for this situation is that there is a great and

⁴⁵C. Hanly, *op. cit.*, p. 196.

growing need for psychologists, especially in service settings. In 1967 the Ontario Department of Health alone had sixty-five listed vacancies for psychologists. These are unfilled positions, and do not include the additional positions that would be created by any expansion of services or improvement in staff:patient ratios.⁴⁶ In order to meet minimum requirements, it has been estimated that more than 100 qualified clinical psychologists are needed in existing and developing health agencies and a similar number in school systems. Larger numbers are required if overall community needs for clinical services are to be met.⁴⁷

On the supply side, the estimates do not provide an optimistic picture. A survey conducted by the Ontario Psychological Association in 1964 concluded that Ontario universities would be producing an increasing number of Ph.D. graduates in psychology during the period 1965-1970.⁴⁸ It was estimated that during this period, universities of Ontario would produce about 900 graduates at the Master's level, of whom about half would continue with graduate work. About 400 Ph.D.'s would graduate, but more than 150 of these could be accommodated by vacancies to be created in Ontario universities within the same period. Another ninety-odd Ph.D.'s would be absorbed into burgeoning university and college departments across the country, while another sixty-six would go into research. Therefore, fewer than 100 would be left to be distributed among the various applied settings in the province. These estimates have already taken into consideration the expansion of existing university faculties and the addition of graduates who will be granted Ph.D.'s by developing programs at Carleton, Windsor, York and Waterloo. Table 13.6 shows an estimate of the detailed dis-

TABLE 13.6

Estimated Number of Ph.D. Graduates Entering Different Fields of Psychology, Ontario, 1965-1970

Year	Teaching	Research	Industrial	Counselling	Educational	Clinical
1965	17	7	1	1	2	6
1966	33	9	0	1	2	7
1967	42	9	1	1	2	11
1968	47	12	1	3	3	11
1969	52	14	2	4	4	12
1970	57	15	1	5	4	14

SOURCE: "Manpower Needs in Psychological Services in Ontario 1965-1970", Report of the OPA Committee on Professional Affairs, OPA Quarterly, Summer 1965.

⁴⁶Survey by R. G. Berry, Adviser in Psychology, Professional Services Branch, Mental Health Division, Ontario Department of Health, 1967-1968.

⁴⁷Ontario Psychological Association, Brief to the Committee on the Healing Arts, 1966, p. 19.

⁴⁸*Manpower Needs in Psychological Services in Ontario, 1965-1970*, Report of the Ontario Psychological Association Committee on Professional Affairs, Ontario Psychological Association Quarterly, Summer 1965.

tribution of qualified psychologists from 1965-1970. It will be seen that the number entering the clinical field, if estimated correctly, will fall far short of estimated demands.

A number of factors are responsible for the shortage of psychologists in the clinical field. Training programs in clinical psychology in Ontario are as yet poorly developed; most Ontario universities have neglected clinical work, giving preference to research and experimental studies. The lack of adequate clinical facilities and good teachers has turned many potential students to other specialties in psychology. Those graduates who have gone into clinical settings often fail to achieve a fully satisfactory professional role. In many hospitals and clinics, they find that the dominance of the medical profession prevents the full development and utilization of their skills. Their salaries and working conditions are also not competitive with those offered by schools and community agencies. In private practice, the clinical psychologist is handicapped by restrictions imposed by existing legislation and by medical insurance plans. These issues will be discussed in greater detail later in this chapter.

Education

The training of clinical psychologists takes place within graduate programs of university departments of psychology. One of the reasons why psychologists find that they are not easily accepted by other disciplines in the mental health field, particularly by the medical profession, is the attitude of skepticism with which the latter view the training background of psychologists, particularly with respect to treatment skills. This skepticism is not unfounded, because training programs in clinical psychology in Ontario are still rather rudimentary.

At present, eleven Ontario university departments provide graduate training leading to graduate degrees in psychology. They are located at the following universities: Carleton, Guelph, McMaster, Ottawa, Queen's, Toronto, Waterloo, Western Ontario, Windsor and York. The Ontario Institute for Studies in Education in Toronto also offers training in psychology. Of these, only Waterloo, Ottawa and Queen's offer separate programs in clinical psychology. Carleton, McMaster, Toronto and Western place the emphasis of their programs on experimental and behavioural psychology and on research; students acquire little or no clinical background.⁴⁹ The Ontario Institute for Studies in Education has a department of applied psychology, but it does not offer a program in clinical psychology. The psychology departments at Guelph and Windsor are only in the early stages of development, but it is intended that programs in clinical psychology will be established. York is currently undertaking the development of a Ph.D. program in clinical psychology and has made arrangements with the Ontario Hospital at Whitby which will serve as a clinical setting for students.

⁴⁹C. Hanly, *op. cit.*, pp. 226-228.

Programs of studies vary greatly from university to university since they do not have to meet any accepted criteria or accreditation in their curricula and training standards. Although efforts have been made by the Ontario Psychological Association to establish standards and provide a machinery for accreditation of applied programs,⁵⁰ there is as yet nothing comparable to the accrediting facilities provided by the American Psychological Association. The Psychologists Registration Act does not provide for the maintenance of such a body. As a result, there are no established minimum standards in academic and clinical work or in specialist studies which any Ph.D. program must meet in order to be accredited. Its content usually depends on the orientation of the particular psychology department concerned, and, to a lesser extent, on the interests of the student. Typically, the student completes a three-year general arts, a two-year Master's and a three-year Ph.D. program. With a four-year honours undergraduate degree in psychology, the Master's program is usually completed in one rather than two years. Practical training is required in all university departments, but most of this is done in research laboratories and classrooms, especially in departments which place their emphasis on general experimental psychology. There is a lack of adequate internship programs for applied psychology from which the student can gain experience in dealing with people and handling clinical situations. For purposes of registration, the candidate is required by the Ontario Board of Examiners in Psychology to have at least one year of experience acceptable to the Board, but this is usually a year of on-the-job experience rather than a formal internship.

At present, graduate education in psychology is dominated by psychologists who are preoccupied with scientific, experimental research. Brilliant clinicians who are needed to teach clinical psychology may be excluded from senior departmental appointments because they do not have sufficient research publications.⁵¹ Most doctoral students in clinical psychology have little experience in supervised clinical practice or in the diagnosis and treatment of behaviour disorders; instead, they are compelled to show research competence by the completion of thesis research which may be of little interest to the candidate and have little or no relevance to his future work. The status of clinical psychology as a profession, uncertain as it is in the mental health field, suffers even more in the universities where it is not accepted as a peer of "academic" psychology.

The Committee is convinced that the clinical psychologist can play an important role in the mental health field, but that university departments of psychology are not producing the number of high quality clinical psychologists needed in the province. The Committee regrets that divisions within the discipline of psychology in Ontario have prevented the development of an optimum number of clinical psychologists, and believes that steps must be taken to ensure that

⁵⁰"Report to the Board of Directors on Standards for Training Programs in Applied Psychology", *OPA Quarterly*, Vol. 20, No. 1, 1967.

⁵¹C. Hanly, *op. cit.*, p. 233.

an adequate number of such persons are available to meet the needs for health services.

Recommendations:

- 158** That at universities where there is a health sciences centre and no clinical psychology program, departments of psychology be encouraged to establish a clinical psychology program and that clinical psychology should be represented in the health sciences centre. Where no program of clinical psychology is established in the department of psychology in universities with a health sciences centre, schools of clinical psychology should be established within the university and with representation on the health sciences centre but not attached to any particular faculty.
- 159** That special funds be made available by the Province of Ontario to provide staff and encourage research in the universities in clinical psychology, in order that greater numbers of students may be encouraged to enter this field with a resulting increase in the number of clinical psychologists.

Role

The work of clinical psychologists involves diagnostic, treatment and rehabilitation services to people who suffer from physical, emotional or intellectual handicap, disability or malfunction.

Most clinical psychologists are employed in the Ontario Hospital system, in psychiatric units of general hospitals, in community and child guidance clinics, in alcoholic and drug addiction treatment centres, and in forensic clinics and reformatories. Private practice is uncommon, and very few psychologists are full-time private practitioners.

The main functions of a psychologist in mental health institutions and clinics are making psychological assessments and diagnosis, conducting therapy sessions (individual and group psychotherapy, behaviour therapy and play therapy, and so on), evaluating ongoing programs of treatment and care, research, and training of other staff members.⁵² However, it is only rarely that we find work settings where the psychologist is engaged in all of these functions. In most hospitals and clinics, he is fully engaged in making psychological diagnoses through tests and assessments. While some psychologists feel that this is their major and unique contribution to mental health services, others regard it as a highly unsatisfactory role. The latter group believe that their training qualifies them for the assumption of greater autonomy and responsibility in the treatment and care of patients. They find that in a hospital where both the administration and the treatment team are headed by physicians, the role of the psychologist is relatively limited. In order to fill the

⁵²Ontario Psychological Association, Brief to the Committee on the Healing Arts, 1966, p. 13.

many vacancies for psychologists, the mental health services of Ontario have encouraged the employment of untrained or semi-trained personnel in psychology. This in turn reduces the status of the profession and forces the most capable psychologists to leave clinical services for work with schools and community agencies where salaries and conditions of employment give greater recognition to the skills and stature of the Ph.D. psychologist.

The Department of Health is undertaking the establishment of positions for hospital administrators in psychiatric hospitals.⁵³ It is hoped that the presence of lay hospital administrators will make the hospital a more congenial place for the development of psychological services. The Committee believes that improvements in the professional status as well as the salaries and working conditions of clinical psychologists will make the field much more attractive to potential students.

Recommendation:

160 That, if it is necessary to provide incentives to obtain more clinical psychologists, the profession should be made more attractive by improvements in salaries and working conditions rather than providing special subsidization of the education of individual clinical psychology students.

Those psychologists who are employed in organizations other than hospitals and clinics appear to have better defined roles and encounter fewer problems of overlapping skills with other mental health professions. In alcoholic and drug addiction treatment centres, the work of psychologists is well distributed in the areas of diagnosis, treatment and research. In forensic clinics and reformatories, clinical psychologists are responsible for all the psychological testing and assessment work and most of the treatment available there to the inmates. Here, psychiatrists play a supporting role largely restricted to consultations with persons convicted of various offences and suffering from a psychosis or a gross psychopathic condition. Significant numbers of psychologists are employed in community agencies which provide counselling and vocational services. Their work is similar to that of psychologists in private practice and is focused on the assessment of aptitudes and intelligence, on vocational counselling, and on working with clients towards the solution of relationship and social problems.

The psychologist in private practice usually has clients referred to him by physicians and psychiatrists with whom he is associated in hospital or other part-time work. He also receives referrals from community agencies, lawyers and clergymen, as well as self-referrals. No psychologists are presently involved in interdisciplinary group private practice, although there did exist two teams of psychologists and psychiatrists, one in Toronto and one in Hamilton. Group private practice, with clinical psychologists as prominent members of a team, is more

⁵³Ontario Department of Health, 44th Annual Report, 1968, p. 77.

common and more highly developed in the United States. A group of some twenty clinics in the New York area, for example, known as the Federation of Mental Health Clinics, is staffed by psychologists, psychiatric social workers and psychiatrists who often act as consultants. These clinics provide diagnostic, treatment and guidance services to the community, and are regulated by the state licensing body.⁵⁴

At present, there are very few psychologists in private practice in Ontario, whether alone or as members of a health team. The Committee believes that the training and skills of clinical psychologists are much needed and can be well utilized in group practice situations.

Another problem which clinical psychologists in private practice have to face is the exclusion of the diagnostic and treatment services they provide from either the Ontario Health Services Insurance Plan or other private supplementary insurance plans. This makes it difficult for psychiatrists or other physicians to refer their patients to psychologists who are not employees of community or government agencies for services, because there is usually no provision for payment of such services except through a direct charge to the patient. The result is not only to limit the availability of psychological services to those who need them, but also to restrict career developments in the clinical field. In the past, psychological services have been provided mainly through government agencies. We have already seen that working conditions and salaries in these positions are not competitive with opportunities in the other psychological fields such as education and industry. The Committee is persuaded that the inclusion of psychodiagnostic and psychotherapeutic services necessary for health care in medical insurance plans would be one of the most effective methods of rapidly increasing the number of clinical psychologists in Ontario. We believe that, given the acute shortage of practitioners in the mental health field, essential mental health services provided by properly trained clinical psychologists should be covered by health insurance schemes.

Recommendation:

- 161 That services of clinical psychologists should be covered under publicly financed health insurance plans, with appropriate safeguards introduced to ensure that coverage is given only for essential health services.

Regulation

The Psychologists Registration Act,⁵⁵ 1960, provides for an Ontario Board of Examiners in Psychology. The responsibilities of the Board are to maintain a Register of psychologists, and to exercise regulatory and disciplinary controls covering the practice of registered psychologists.

⁵⁴C. Hanly, *op. cit.*, pp. 224-225.

⁵⁵R.S.O. 1960, c. 316.

The Board of Examiners consists of five members, appointed by the Lieutenant Governor in Council, each for a five-year period. All members of the Board must themselves be registered psychologists, and a minimum of two and a maximum of three must be principally employed as university teachers. The Board appoints a registrar who is its employee charged with maintaining the Register, and with preparing and submitting to the Board cases for its decision. From time to time, the Board employs examiners. The Board may register, refuse to register, suspend or cancel the registration of psychologists.

The Psychologists Registration Act prohibits an unregistered person from holding himself out to the public

. . . by any title, designation or description incorporating the words "psychological", "psychologist", or "psychology" and under such title, designation or description [offering] to render or [rendering] services of any kind to one or more persons for a fee or other remuneration.⁵⁶

The Act does not specify the type of services a registered psychologist is allowed to provide. According to Section 12 of the Act,

No person who holds a certificate of registration shall treat any person for any type of mental disorder for a fee or other remuneration except on the request of or in association with a duly qualified medical practitioner.

The purpose of this restriction was to avoid the danger of an undiagnosed physical illness in a patient which may be concomitant with, contributing to, or the single cause of his psychological symptoms. This restriction makes it difficult for a clinical psychologist to take patients directly without referral from a medical practitioner. Psychologists believe that this is detrimental to the status of their profession in the mental health field, and is partly responsible for the low number of qualified psychologists entering private practice. The Committee recognizes the need for adequate provision for medical intervention to deal with any possible physical illness in mentally ill patients. We are aware also that provision for appropriate medical consultation is stated under Principle 2(b) of the Ethical Standards for Psychologists, subscribed to by members of the Ontario Psychological Association. The Committee also notes that section 13 of the Psychologists Registration Act prohibits the registered psychologist from engaging "in any manner in the practice of medicine, surgery, or midwifery".

Recommendation:

- 162** That certified clinical psychologists should be able to take patients directly, but where a patient has not been referred by a qualified medical practitioner, psychologists must arrange for a medical examination to ensure that the problem is not physical or organic in nature before treating the patient.

⁵⁶R.S.O. 1960, c. 316, s. 11(2).

A serious weakness in the Psychologists Registration Act is that it does not differentiate between professional and academic qualifications or between various specialties in the applied field. Thus, a psychologist who satisfies the minimum requirements of the Ph.D. and the Board examinations would be legally qualified to provide services within the meaning of the Act. His registration gives him a "blanket" licence to practise without regard to his area of specialization and competence. He may therefore be practising in a clinical setting when his training has been wholly experimental. This may not be a common practice, but there is evidence that this does happen as a result of the shortage of personnel in all branches of applied psychology.

The Committee believes that an adequate registration system would have to be premised on different types of internships and examinations for the different specialties within psychology. It follows that the certification of clinical psychologists and the regulation of their practice should be the responsibility of a Clinical Psychologists Certification Board, set up under legislation which is separate from the existing Psychologists Registration Act. This certification board would be responsible for setting up and maintaining minimum training standards and for evaluating and accrediting graduate programs in clinical psychology. Ideally, accreditation should be on a national basis; but as there is no established organization which performs this function, the Committee believes that machinery for accreditation should at least be available on a provincial basis.

Recommendations:

- 163 That legislation be enacted for the certification of clinical psychologists under a Clinical Psychologists Certification Board.
- 164 That the members of the Clinical Psychologists Certification Board should, as in the case of other professional regulatory bodies, be elected from among the registrants with representation from the Department of Health and significant lay representation included on the Board. The initial Board, however, should be appointed by the Lieutenant Governor in Council for an interim period.
- 165 That no psychologist except one certified by the Clinical Psychologists Certification Board be permitted to hold himself out as qualified to practise in the field of mental health. Exemptions, however, should be allowed for psychologists in the employment of federal or provincial governments or by a university. The qualifications for certification as a clinical psychologist should remain at the Ph.D. level with one year's experience in clinical psychology continued as a requirement.

At present, programs of studies are approved on an individual basis by the Board of Examiners. No procedures are set out in the Act whereby a clinical psychologist who is qualified to practise in a jurisdiction outside Ontario may become qualified to practise in the province.

Recommendation:

- 166** That the Clinical Psychologists Certification Board make provisions for certifying persons as clinical psychologists who have received their training in clinical psychology outside Ontario where the clinical psychologist's education and experience are deemed equivalent to that which is required in Ontario.

The Committee also believes that in clinical psychology, as in many other groups in the health field, continuing education should be made compulsory to ensure the competence of the registered practitioner.⁵⁷ At present, this is not a requirement for maintaining registered status with the Board of Examiners.

Recommendation:

- 167** That a program for ensuring continuing competence be implemented for clinical psychologists and that periodically, perhaps every five years, every certified clinical psychologist in Ontario be required to present to the Clinical Psychologists Certification Board a certificate from an appropriate university department of psychology, stating that he has maintained a satisfactory level of competence in the area of psychology in which he ordinarily practises.
- 168** That the university departments of psychology in Ontario develop the standards and programs required for such certification; these could include formal course work, contribution to the profession through research or teaching or other appropriate methods. Such standards and programs should take cognizance of the nature of the practice of individual clinical psychologists.

Voluntary Association

The Ontario Psychological Association, founded in 1947 and incorporated in 1951, is an independent voluntary body of psychologists established with the aim of promoting psychology both as a science and as a profession. The Association is controlled by a board of five directors who are elected by the full members and associate members of the Association.

Members of the Association need not be registered psychologists. The requirement for full membership is a Ph.D. degree in psychology or the equivalent; that for associate membership, an M.A. degree in psychology or the equivalent. In 1965, the OPA had 168 full members and 147 associate members.

The Association has two committees appointed by the Board of Directors, the Executive Committee and the Committee on Professional Affairs. The latter main-

⁵⁷See discussion in Chapters 25 and 26.

tains the Code of Ethics, advises on the need and policies for professional training, and gives guidelines to insurance agencies on coverage for psychological services in health insurance plans.

The Association performs to a large extent the function of disciplinary control and maintenance of ethical standards, based on the Code of Ethics of the Canadian Psychological Association which covers comprehensively all aspects of a psychologist's practice. Complaints against registered and/or non-registered persons, alleging violation of the Act, which are brought to the Registrar are dealt with in the following manner:

- 1) Upon receipt of a written complaint the Registrar, at his discretion, informs the Board of (a) the nature of the complaint, (b) the name of the person or firm against whom the complaint is made, and (c) the name of the person by whom the complaint was made.
- 2) The complaint is referred to the Ethics Committee of the Ontario Psychological Association for action and/or recommendation.
- 3) The action and/or recommendation of the Ontario Psychological Association Ethics Committee is reported to the Board, which then determines (with the advice of the Board's legal counsel) if more formal legal steps are indicated.

This procedure has been adopted in order to guard against prejudicing the quasi-judicial role of the Board in reviewing any individual's right to hold a certificate of registration.⁵⁸

The Association publishes from time to time prevailing salary scales for psychologists employed in various settings. For those who are engaged in private practice, the Association does not set a fee schedule but does provide certain guidelines for remuneration for professional services.⁵⁹

Psychometrists

A very important group of clinical psychological personnel should also be mentioned here to complete the picture of the profession in Ontario. These are the "psychometrists" who carry out the more routine diagnostic tasks and participate in treatment programs under supervision in psychological settings.

The majority of psychometrists possess a Master's degree in psychology; others may have a Bachelor's degree with a major in psychology or in an allied discipline such as sociology or anthropology. The only training program in Ontario

⁵⁸Ontario Board of Examiners in Psychology, Registrar's Report. 1963-1964, *Ontario Psychological Association Quarterly*, Vol. VXII, No. 3, Winter 1964.

⁵⁹Ontario Psychological Association, *Ethical Standards of Psychologists*, Principle 12.

which is specifically designed for psychometrists was first introduced by the University of Waterloo in 1966. This program has a strong practical orientation and is unlike the general research degree programs offered elsewhere in that it teaches the student a specific set of skills which fills a service need in applied settings.

There is a great demand for psychometrists in mental hospitals and clinics, in rehabilitation and reform institutions, and in community agencies. This demand has been created in part by the shortage of well-trained clinical psychologists. Thus, we find in many instances that experienced psychometrists are being employed to fill positions which call for qualified psychologists. Psychometrists perform a wide range of functions depending on their training and experience, and on the staffing situation of the particular setting in which they practise. In general, they administer, score and interpret tests of intelligence, aptitude and personality. They perform record keeping and other clerical duties related to psychological treatment. Under supervision, they participate in psychotherapeutic and activity programs of an individual or group nature, and assist in the application of research techniques and in the training of non-professional staff.

The importance of psychometrists as a source of psychological manpower supply can be seen in Table 13.5 on p. 298. Of the 230 full-time psychological staff employed in Ontario's mental health facilities in 1966, only forty-one (17.8 per cent) were Ph.D.'s, 124 (53.9 per cent) had Master's degrees and the remaining sixty-five (28.3 per cent) had Bachelor's degrees or other qualifications. As we have pointed out earlier, clinical settings constitute one of the least attractive fields for the Ph.D. psychology graduate. A national survey of psychologists sponsored by the Canadian Psychological Association in 1966 indicated that one-half of those with doctoral degrees in psychology are engaged in research, teaching or writing, while only one-fifth are in service functions. On the other hand, half of those with Master's level training indicate principal service functions, with less than an eighth in research, teaching or writing. The survey also found that of the service functions, clinical and counselling psychology employed the lowest percentage of persons with doctoral degrees. In 1966, only 27 per cent of the psychological personnel in these areas held doctorates. This figure compares with 60 per cent of doctorates in the same fields in the United States in 1964.⁶⁰

The presence of this high percentage of subprofessionals in clinical settings may indicate a less than satisfactory standard of psychological services, especially where there is insufficient supervisory staff. The Committee has made recommendations to expand and strengthen postgraduate training programs for, and to improve the working conditions of, clinical psychologists. The adoption of these recommended measures to increase qualified personnel in the field becomes more urgent in the light of this situation.

⁶⁰M. H. Appley and Jean Rickwood, *op. cit.*

Other Personnel

Psychiatric Social Workers and Psychiatric Nurses

Psychiatric social work and psychiatric nursing are paramedical disciplines which are essential to effective modern treatment and care of the mentally ill. Man-power resources in these two fields are mostly drawn from the general pool of social workers and nurses who have a wide range of professional activities which are not confined to the mental health field.

Discussions and recommendations concerning these two professional groups are, therefore, included in the chapters on social workers (Chapter 14) and nursing (Chapter 10).

Child Care Workers

Child care workers are responsible for the daily care of emotionally disturbed children in residential institutions. Under the supervision of senior mental health professionals, they make informed observations of the patient's total needs in relation to his disturbances and relate therapeutically to them. Traditionally, though on a small scale, these functions belonged to nurses with psychiatric training. However, the inadequate preparation of nurses for the therapeutic tasks in psychiatric treatment centres has gradually turned nurses away from this field. As a result, child care work has been developed to fill this service need.

Formal training courses have been introduced only recently and have been preceded by a number of successful in-service training programs organized by public and private treatment centres for emotionally disturbed children. The first child care course in Ontario was started in 1965 at Thistletown Hospital through the efforts of the Ontario Welfare Council's Committee on Children's Institutions. Later a course was set up at the Provincial Institute of Trades and Occupations (later to become the George Brown College). Other Colleges of Applied Arts and Technology such as Fanshawe in London followed suit.⁶¹

Child care work training courses are now offered at three Colleges of Applied Arts and Technology and three Department of Health operated institutions. The three colleges are George Brown College, Fanshawe College and St. Lawrence College; they expect to be graduating between them about fifty to sixty workers each year by June 1970. Other colleges planning to develop courses are Conestoga College (Kitchener), Niagara College (Welland), Seneca College (Willowdale) and Mohawk College (Hamilton).⁶²

The Department of Health courses are offered at Thistletown Hospital and Warrendale, Children's Psychiatric Research Institute (London) and Lakeshore

⁶¹C. Hanly, *op. cit.*, pp. 165-166.

⁶²Report of a Survey on Residential Services for Adolescents conducted by the Section of Child Psychiatry, Ontario Psychiatric Association, 1968.

Psychiatric Hospital, with a total enrolment of 167 in 1968. New programs will be organized at the Ontario Hospital, Kingston, the Royal Ottawa Sanatorium and the C. M. Hincks Treatment Centre, Toronto. The Department expects to have a total enrolment of 325 by 1970.⁶³

Many private residential centres for emotionally disturbed children also offer similar courses — for example, Sacred Heart Children's Village, Browndale (formerly Brown Camps Ltd.).

The standard and content of these courses vary from one centre to another. Generally speaking, there is a grade twelve training prerequisite. The course usually spans a two-year period made up of formal lectures and seminars, and supervised in-service training in various centres for mentally disturbed children. The training course organized by Browndale is unique in that, besides the formal lectures and practical experience given, there is a therapeutic component with the trainee as a patient in group psychotherapy. The purpose of this component is to remedy any psychopathology in the child care worker himself and to provide a situation whereby the child care worker can share problems in his work with his peers. Most of the recruits at Browndale have some university education and some have university degrees.

Because of the limited training received by a child care worker, it is important that a precise limit to his or her competence be drawn. However, the role of the child care worker, like his training and admission standards, varies from centre to centre. There are no established criteria and guidelines for training, nor is there any machinery for the accreditation of programs and recognition of the qualifications of graduate child care workers.

In answer to the need of establishing and maintaining standards for training in child care work, a Co-ordinating Committee on the Training of Child Care Workers has recently been established. This Co-ordinating Committee consists of representatives from the Mental Health Division of the Department of Health, from the Department of Education of Thistletown Hospital and from George Brown College of Applied Arts and Technology. It attempts to survey and co-ordinate standards in child care work training, making recommendations when indicated to the Deputy Minister of Health.⁶⁴

The Committee recognizes the importance of maintaining minimum standards in child care work training. But at this early stage of the discipline's development, it would be unwise to impede training programs undertaken by private agencies or prevent graduates from such programs from obtaining jobs elsewhere. On the other hand, training programs in the province's Colleges of Applied Arts and Technology should be developed and the Committee urges that evaluations be made of these courses and the effectiveness of their graduates by the Ontario Council of Health and the Department of Health.

⁶³*Ibid.*

⁶⁴Report of a Survey on Residential Services for Adolescents, *op. cit.*

The Committee also believes that child care work should not be restricted to those who have completed a formal course of training. In some instances mature women who may have raised their own families can make an important contribution to this field with only appropriate on-the-job training.

Recommendations:

- 169** That programs for the education of child care workers be established in Colleges of Applied Arts and Technology, and that an Educational Advisory Committee for Child Care Work be appointed to advise the Minister of Education on length of programs, curriculum, and so on. Such programs should have as entrance requirements completion of grade twelve and should be not longer than two years. Students with advanced standing, grade thirteen or some university credits should be given the opportunity to complete the course in less time.
- 170** That any education programs for child care workers be carried on in cooperation with the employers of child care workers in order that the educational experience may be as profitable as possible and that adequate opportunities are made available for practical experience.
- 171** That at this time, child care institutions not be prevented from conducting their own training programs for child care workers which may emphasize a particular philosophy or type of treatment.
- 172** That no provincial licensing or certification be introduced at this time for child care workers.

Hospital Aides and Attendants

This group of workers provide services mostly in adult psychiatric settings similar to those performed by child care workers in residential institutions for emotionally disturbed children. Aides and attendants are becoming increasingly important as experimentation and improvement in mental health services proceed.

The main work of the aides and attendants, beyond custodial care and supervision, is to provide what is described as remotivation. Their work is highly regarded by psychiatrists and nurses. In many cases, they are the only persons within the hospitals coming from the same social class as many of the patients who share their values and goals. The concept of milieu therapy, which is being emphasized by most psychiatric institutions, requires that these persons should be able to interact constructively with patients and that they should have some rudimentary understanding of the nature of mental illness.

The need to provide these ancillary workers with some formal training is recognized by the Ontario Hospitals where ten-month courses are offered to aides and attendants. These programs are inspected by the Ontario College of Nurses and those which meet the standards set up by the College are accredited as

registered nursing assistant programs. Graduates of accredited schools are recognized as registered nursing assistants. Programs have now been approved by the College of Nurses in ten psychiatric hospitals.

The Committee endorses the effort of the Ontario Hospitals and the College of Nurses to upgrade the training of ward staff. The Committee sees this as a progressive step in the development of a higher level aide and attendant who can provide a greater contribution to the mental health team, and who will have an increased status and pay which should attract better applicants to these positions.

Mental Health Clergy

Mention should also be made of those members of the clergy who are actively involved in the mental health of the community as hospital chaplains and as specialists in pastoral counselling in specialized settings. A growing number of clergymen in Ontario have now undertaken a special form of training known as "supervised" or "clinical pastoral education", which was introduced some forty years ago in the United States enabling clergymen better to perceive the mental health needs of the parishioners. Various types of full-time and part-time training programs are now available to the pastors and theology students in Ontario in universities and hospitals. The programs are accredited on a national basis by the Canadian Council for Supervised Pastoral Education. Graduates of this program may continue their work in a parish setting or they may be employed in public institutions—for example, in hospitals, reformatories, alcohol and drug addiction treatment centres and community counselling agencies. It is undoubtedly true that the trained pastor, informed in the problems of the mentally ill, can make a valuable contribution to the mental well-being of the community at large.

Conclusion

The role performed by each of the above groups of professionals and subprofessionals varies with the setting in which they practise and is conditioned by the interprofessional relationships which develop within these settings. These relationships are in turn conditioned by the professional resources in the various locations. In general, psychiatrists dominate the provision of mental health care, and where their services are available in sufficient quantity, their non-psychiatric colleagues perform very limited and specific diagnostic and therapeutic functions. Extensive participation in diagnosis and/or therapy by other mental health professionals occurs in most settings, either by default or at the discretion of a psychiatrist convinced of their potential.

In the psychiatric units of public general hospitals, with their essentially medical orientation, psychiatrists outnumber their other medical colleagues. The professional staffs of these units usually comprise full-time and part-time appointees in psychiatry, clinical psychology, and social work; some enjoy the services of psychiatric nurses and some utilize the services of general practitioners

as clinical assistants or by allowing them admitting privileges. Although patterns of interaction vary, the medical personnel bear ultimate legal responsibility for care, and are most intimately involved in diagnosis and in the planning and administration of treatment. According to Hanly's survey, physicians in such units estimate that 30 per cent of their work is of a purely medical nature.⁶⁵ The primary contribution of clinical psychologists is in the area of diagnostic testing, although some, at the discretion of the psychiatrist, engage in psychotherapy. Social workers may be confined to such traditional functions as social history taking and the counselling of friends and relatives of psychiatric patients; however, the few who possess adequate training may be involved in the provision of psychotherapy both with individual patients and with families.⁶⁶ General practitioners participate extensively in both diagnosis and therapy, but rely considerably upon the advice of their psychiatric consultants. The role of the nurse exhibits the greatest variation. Those who, in the opinion of the psychiatrist, possess adequate training, experience or aptitude may engage under his formal or immediate supervision in psychotherapeutic activity.

Interprofessional relationships in Ontario Hospitals are similar to those discussed above. The numerical predominance of the medical profession, however, is not as great, and the contributions of the non-medical professions and subprofessions to therapy are more extensive. Hanly cites the Ontario Hospitals at Kingston, Hamilton and Whitby, and the Lakeshore Hospital, Toronto, as institutions in which the contributions of clinical psychologists are particularly significant.⁶⁷ The potential contribution of the nurse to therapy is being increasingly recognized in Ontario Hospitals. For example, at the Ontario Hospital, Hamilton, nurses are engaged in group psychotherapy; at Northeastern Psychiatric Hospital, Porcupine, with only one full-time psychiatrist and one psychiatric resident, nurses are actively and directly involved in managing and conducting programs of therapy.⁶⁸ Ideally, involvement in therapy extends to subprofessional personnel such as aides and orderlies, insofar as they are to form support elements within the therapeutic "milieu", but in practice their functions extend little beyond those which they have traditionally performed in general hospital care. In addition to these mental health workers, another type of personnel, the hospital administrator, is appearing in increasing numbers of Ontario Hospitals and relieving psychiatric staffs of the administrative duties with which they have long been overburdened.

Interprofessional relationships within the outpatient services of these public mental hospitals are similar to those which characterize their inpatient wards. Psychiatrists are predominant, both numerically and functionally, and bear ultimate legal responsibility for treatment. However, there appears to be somewhat

⁶⁵C. Hanly, *op. cit.*, p. 268.

⁶⁶C. Hanly, *op. cit.*, p. 269.

⁶⁷*Ibid.*, p. 273.

⁶⁸*The Globe and Mail*, Toronto, November 7, 1968.

greater involvement of clinical psychologists and psychiatric social workers in such services.⁶⁹

The role of clinical psychologists, psychiatric social workers and nurses with or without formal psychiatric training increases in those facilities which experience difficulty in attracting psychiatrists: private residential treatment centres for children, private voluntary family service agencies, and non-medical public institutions such as schools and reform institutions. Most of these facilities are afforded the services of psychiatrists on a part-time or consultant basis only. Private residential treatment centres for children utilize psychiatrists' skills primarily for diagnostic purposes; custodial care and limited therapy in the form of counselling is provided by their full-time staffs of social workers and child care workers. Scarcity of professional resources within the Department of Reform Institutions has also led to the assumption of limited therapeutic functions by the few social work employees and by some subprofessional personnel. The services of psychiatrists, available only on a part-time basis, and of psychologists and psycho-metrists, some of whom are employed full time, are directed almost exclusively towards diagnosis.⁷⁰ Severe cases are referred elsewhere for treatment.

Services rendered by mental health professionals to public schools within the province are almost exclusively of a diagnostic nature. Psychologists and psycho-metrists, with their skills in aptitude and vocational testing and counselling, far outnumber either psychiatrists or social workers, but even the former two groups are in short supply.⁷¹ Virtually the only mental health professionals employed full time by family service agencies are social workers, although some employ part-time psychiatrists and others enjoy some psychiatric consultations, both from mental health clinics and from private psychiatrists. The role of the psychiatrist here involves diagnosis and the treatment, on a referral basis, of more severe disorders. Social workers employed by the agencies are intensively involved in casework and counselling of less severely disturbed patients and their families, and in follow-up care of those treated by psychiatrists. Psychological services are seldom utilized by family service agencies, but occasionally the latter consult with or refer to psychologists associated with mental health clinics, schools, and Ontario Hospitals. The relationships of these agencies with general practitioners are most satisfactory. When medical advice is deemed necessary, consultation with the client's family physician is the usual practice. Clients without family physicians, if they possess insurance coverage, are referred to a private practitioner. Uninsured clients are referred to outpatient departments of general hospitals.⁷²

As in the health system as a whole, the means of increasing the availability of mental health services lie not only in training more personnel but in defining new

⁶⁹C. Hanly, *op. cit.*, p. 310, Table 13.11.

⁷⁰*Ibid.*, p. 337.

⁷¹*Ibid.*, pp. 316-320.

⁷²*Ibid.*, p. 356.

patterns of interrelation to ensure a more effective utilization of their skills. The development of these patterns must be informed by the nature of the services to be provided, rather than by the professional structures whose insular educational and regulatory procedures have created both formal and informal barriers to interprofessional cooperation. The evidence suggests that physicians in particular, educated as they were in virtual isolation from psychologists, psychiatric social workers and other mental health practitioners until recently, have failed to develop sufficient awareness of non-medical skills or the efficacy of those skills in the treatment of mental illness. Mental health is only one of many fields in which organized medicine has assumed medical primacy as desirable and inevitable, and been slow to accept or encourage the creation of other categories of trained personnel. Yet it must be recognized that there is no present prospect that enough psychiatrists or other medical practitioners will be available to meet high and rising demands for mental health services; other types of non-medical personnel also must be trained and effectively utilized in conjunction with physicians if demands are to be met. In their educational programs as well as their practices, physicians must be made more aware of the useful functions of other healing disciplines and assist in bringing about better training and more extensive utilization of other types of mental health workers. What is needed, then, is flexibility and experimentation in training centres, to devise more effective methods of utilizing mental health personnel, and to instill in trainees an awareness of the potential contribution of a variety of other professionals to mental health care.

Furthermore, this flexibility and experimentation must also characterize the approach to the various modes of therapy presented in the training programs of mental health personnel. The introduction to this chapter referred to theoretical divisions among the mental health professions in the face of inadequate knowledge concerning the causes and treatment of mental illness as one of the major hindrances to interprofessional cooperation in practice settings, in training, and in manpower and program planning. Information upon which to base choices or to work compromises among various alternatives is urgently required.

Recommendation:

- 173** That the Government of Ontario and the universities in Ontario place greater emphasis on and provide more financial resources for research into the causes and treatments of mental illness, and that until there is more substantial evidence, no one mode of therapy be emphasized exclusively in the training of mental health workers.

Chapter 14 Medical and Psychiatric Social Work

The Committee has confined its investigation to those of the various kinds of social workers who work in the health care field, particularly the two subcategories of medical and psychiatric social workers. To provide a basis for our study we not only relied on our standard procedures, but in addition had two research projects carried out in this connection. Charles Hanly prepared a study on *Mental Health in Ontario*, which provides information on psychiatric social work.¹ And our internal research staff prepared a separate study of social work based on a questionnaire survey.²

Although approximately one-third of social workers are male, for the sake of convenience in this chapter we refer to social workers as female.

Definition and Changing Concepts

Social work is widely defined as follows:

Social work is a professional activity in which knowledge about the interaction of man and his environment and skill in helping relationships with people are used to enable people to attain a greater adequacy in their social functioning.³

In its Report the Hall Commission discussed the role of medical social workers in the provision of health services:

Social work has gained an essential role in the provision of good health services and as the social component in sickness has become more recognized, the contribution of the medical social workers has become increasingly more significant. They are employed in hospitals, clinics, and rehabilitation centres and deal with social problems of patients and their families.⁴

Developments in the health field in recent years have included, in addition to increased emphasis on social medicine, an elaboration of the concept of multi-

¹C. Hanly, *Mental Health in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Ch. 9.

²M. Landauer, *Social Work in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970.

³Reverend Swithun Bowers, O.M.I., in Canadian Association of Social Workers, "Proposed Policy Statement on Professional Competence in Social Work Practice", 1967, mimeo., p. 3, quoted in M. Landauer, *op. cit.*, p. 2.

⁴*Report of the Royal Commission on Health Services*, Vol. II, Queen's Printer, Ottawa, 1965, p. 63.

phased comprehensive health care, with emphasis on prevention and rehabilitation as well as diagnosis and treatment.

Both these developments towards social medicine and comprehensive care have had in common the effect of focusing attention on the importance of social and emotional factors in health and sickness. These broadened conceptions of health, as well as other trends in the health care field — such as increased attention to mental health problems, and commitment of resources to their treatment — and the trend towards enlarged community health programs, have highlighted the function of social work in health care. In 1967 there were in Ontario 221 social workers employed in psychiatric hospitals, 125 of whom had either an M.S.W. or B.S.W. degree; and 143 in public general hospitals, seventy-six of whom held either an M.S.W. or B.S.W. degree.⁵

Historical Origins of Medical and Psychiatric Social Work

Most narrowly conceived, medical social work originated in London in the 1870's, where almoners were introduced into hospitals as a form of low cost care in the charitable sector of hospital services. Some doctors, however, protested that patients who should be coming to their private offices and paying fees were using the hospital outpatient dispensaries free. A special meeting of London's Medical and Chirurgical Society was called in 1870 to discuss what they perceived as an abuse of this outpatient system. The doctors warned that if relief were too easily obtainable, it would not lead to habits of foresight and self-reliance and would be detrimental to national life. These and other criticisms led the Charity Organization Society to set up a committee for study of the social position of outpatients at the dispensaries in 1872. By 1885 the Chairman of the Charity Organization Society proposed setting up the new job of "charitable assessor or coordinator" to examine the eligibility of applicants for free treatment in the clinics. In 1895 the first almoner was appointed to London's Royal Free Hospital.

Other forerunners of medical social work that implied a somewhat broader conception of the scope of social work in health settings include the movement for the after-care of the insane, which spread outward from Germany in the early part of the nineteenth century; the visiting nurse movement, which began in England in 1893; and the field training of medical students, which was initiated at Johns Hopkins Medical School in 1902 by Sir William Osler. Osler introduced social work into the curriculum and assigned medical students as friendly visitors to tubercular families.

Dr. Richard C. Cabot pioneered the introduction of social service departments into American hospitals when he established one in the outpatient department of the Massachusetts General Hospital in Boston in 1905. Five years later, in 1910, Canada's first hospital social service department was opened in the Montreal

⁵See Table 6.3, Vol. 1, Chapter 6.

General Hospital. The Toronto General Hospital established a social service department in 1919.

Dr. Cabot organized the social service department in the outpatient facility of the Massachusetts General Hospital to "serve the patient in his real trouble, whatever that might be Real trouble is understandable and helpable only when you know . . . bodily states . . . mental states . . . bodily environment . . . and mental environment" ⁶

Most physicians, however, tended to limit the function of social work in the general hospital to working with the problems of poor patients when social circumstances undermined medical treatment. Until recent years, many physicians held a somewhat narrow and unfavourable attitude towards hospital-based social work. If the majority of physicians today do not hold such an attitude, they are still not as enthusiastic about the usefulness of social work in the health system as were pioneers such as Dr. Cabot, and Dr. Malcolm P. MacEachern, who predicted:

In the future, the medical social worker will be as valuable in supplementing the work of a specialist practising exclusively among the wealthy as she has been, and is, to physicians caring for the sick who are financially less fortunate. ⁷

Role

Until 1955 social work in Canada and the United States was divided into a variety of separate sections, so that there were associations of psychiatric social workers, medical social workers, and school and probation social workers. This separation of specialties was also characteristic of training programs.

In 1955 the National Association of Social Workers in the United States was established to unify the discipline. The aim of the Association was to encourage a general common base of competence and of function on the part of social workers, whatever their specific field of vocational activity might be. The rationale behind the concept is that social work in whatever setting it is practised is basically similar — that the elements of practice common to all settings are far more significant than the elements particular to any single setting. This is the formal position of the Association; thus the policy pursued by the Council on Social Work Education is that there be no specialization of either accreditation or curriculum, in terms of subdisciplines such as psychiatric social workers, in the basic training of social workers.

However, a significant minority (about 30 per cent) of social workers practising in the medical and psychiatric fields in Ontario look on medical and psychia-

⁶From Laura Jackson, *Hospital and Community*, Macmillan, New York, 1964, p. 91, quoted in M. Landauer, *op. cit.*, p. 28.

⁷Dr. Malcolm P. MacEachern, *Hospital Organization and Management*, 2nd ed., Physicians Record Co., Chicago 1935, quoted in M. Landauer, *op. cit.*, p. 29.

tric social work as being sufficiently different from social work practised in any other context to warrant specialized education and registration as medical or psychiatric social workers.⁸

Medical Social Workers in a Hospital Setting

The role expectations of the medical social worker in a hospital setting are in conflict with what physicians see as the medical social worker's proper sphere of responsibility. A study conducted at the University of Michigan Medical Centre⁹ revealed that in only five areas of responsibility was there agreement among the majority of doctors and social workers that the areas were properly the responsibility of social workers. These were listed as follows:

- 1) Gathering social histories of patients to supplement medical histories.
- 2) Helping families of patients with social problems related to the patient's illness, disability or impending death.
- 3) Helping patients with social problems related to their illness, disability or impending death.
- 4) Making referrals to, or arrangements with, appropriate community agencies regarding custodial, convalescent or institutional care for patients who require post-hospital care.
- 5) Making referrals for community services (visiting nurse, visiting teacher, family counselling service and the like) for patients returning home after discharge from the hospital.

The extent of conflict in the expectations of the medical and social work professions as to the proper function of social work can be illustrated by a few examples. Although a large majority of physicians expected social workers to secure financial assistance for patients when it was needed, most social workers rejected this responsibility as inappropriate to their role. Only 13 per cent of the physicians thought that social workers should help patients with their emotional problems, and only 50 per cent thought that social workers claimed to be competent to help patients with emotional problems; but of the social workers interviewed, over 95 per cent believed that emotional problems of patients should be within their working responsibility, and 60 per cent believed physicians were willing to grant them responsibility in this area.

Less than 25 per cent of the physicians, but 100 per cent of the social workers, considered that helping patients adjust to the hospital should be part of the social worker's role. Sixty-six per cent of the physicians perceived social workers as

⁸M. Landauer, *op. cit.*, p. 29.

⁹Katherine M. Olsen and Marvin E. Olsen, "Role Expectations and Perceptions for Social Workers in Medical Settings", *Social Work*, Vol. XII, No. 3, July 1967, pp. 70-78.

claiming working responsibility for this task. Strikingly, over 80 per cent of the social workers believed that physicians were willing to delegate the task to them.

The study concludes:

. . . physicians apparently see medically related emotional problems as an essential part of the patient's over-all condition for which they hold themselves responsible. Social workers, however, define this activity as one of the professional services they are particularly competent to provide.¹⁰

Another source of conflict between social workers and physicians in a hospital is the aspiration of many of these highly qualified social workers to make an independent final judgment in the practice of social therapy.¹¹ Many graduate social workers insist that social work in the health setting should not be considered in the same way as nursing, physiotherapy or laboratory technology. They maintain that, while the nurse or therapist cannot demand an independent final judgment in her field of practice, the social worker must insist on it.

The graduate social worker often views her functions as those of a skilled therapist concerned more with the intrapsychic and interpersonal aspects of the social problems of medical patients than with the financial and material aspects. Many social workers consider physicians, for the most part, uninterested in and having no special competence to treat the emotional and environmental factors in a patient's medical condition. The realization of these aspirations of some of the more professionally self-conscious social workers for final say in social therapy would require institutionalization of the team approach to diagnosis and treatment in the general hospital setting. Although the team approach has been instituted in several mental hospitals, it is very rarely found in the general hospitals. The physician, whether specialist or general practitioner, is used to assuming full and exclusive responsibility for his patients during the period of their hospitalization. To the extent that he is more and more frequently utilizing the services of other professions and occupations, he does so for technical or clearly defined and limited purposes; and he expects in most cases (at least formally) to maintain full authority over the nature and duration of the services provided by ancillary groups.¹²

If, in spite of these attitudes of most private physicians and many staff physicians working in the hospital, a good deal of medical social work involves complex social and emotional problems and significant autonomy for the social worker, it is because between 40 per cent and 50 per cent of medical or psychiatric social work services typically are provided to outpatients, many of whom have no private physician. Some inpatients also may have no private physi-

¹⁰*Ibid.* See also M. Landauer, *op. cit.*, pp. 33-35.

¹¹M. Landauer, *op. cit.*, p. 35 (based on interviews with Dr. W. I. Taylor, Executive Director of the Canadian Council on Hospital Accreditation).

¹²M. Landauer, *op. cit.*, pp. 35-36.

cian, and the staff physicians may be more willing to refer these patients to social workers, even when a relatively complex social or emotional problem is known or suspected.¹³

Obstacles to the extension of skilled social work services to patients in the hospital or community whose social problems are not associated with financial difficulties come from sources other than physicians. Patients themselves in the middle-income levels are reluctant to accept the services of social workers. Many do not regard social work as part of the health care system because it is often identified with poverty and welfare programs.¹⁴

In spite of such obstacles, there are changing trends in attitudes towards social work. There is a growing acceptance by physicians of the need to collaborate with other disciplines such as social work in the treatment of many illnesses. On the other hand, the social worker must also be aware that when she comes into the hospital from a community agency setting where she has had primary responsibility for a case, her autonomy may be limited, and her position may be closer to that of a medical auxiliary.

Social Work in Psychiatric Settings

To this point, the discussion of social work in the health field has been focused on the general hospital setting. However, more social workers at every level of training are found working in mental and psychiatric hospitals than in public general hospitals, although of course there are fewer beds in these institutions than in the general hospitals. In addition, many (20 to 30 per cent) of the social workers in the general hospitals are working full time in the psychiatric departments or mental health clinics of these institutions.¹⁵ That more social workers are found in psychiatric settings may be explained in part by the attraction that employment in psychiatric hospitals relative to working in general hospitals holds for social workers. The types of illness and the treatment methods emphasized in the psychiatric settings hold a greater fascination for most social workers and probably seem much more relevant. Psychiatry, of all the branches of medical specialization, has been best prepared and most willing to make use of the knowledge and skills of the social worker. Most social workers view their special area of competence as diagnosing and treating individuals and families whose social or emotional problems are blocking their self-fulfilment or their capacity to function adequately as members of society. In this commitment they share agreed goals, and to a large extent methods, with psychiatry far more than with the other branches of medicine. At the same time they can appreciate that the psychiatrist has more knowledge and competence in this field.

¹³*Ibid.*, pp. 36-37.

¹⁴*Ibid.*, p. 42.

¹⁵*Ibid.*, p. 45.

Another factor explaining the attraction of employment in a mental health institution for social workers is that the "team" approach to diagnosis and treatment is more highly developed in many of the mental and psychiatric hospitals than in many of the general hospitals. Thus the skilled social worker often feels that her training is being more fully utilized and her status increasingly respected in psychiatric settings.

Hanly outlines four differing conceptions of the nature and training of a psychiatric social worker.

- 1) A psychiatric social worker is a general social worker employed in a mental health service. His functions usually include the following: taking social histories of patients; establishing effective liaison with families of patients or social agencies that will be needed by the patient during his hospitalization; assisting patients with post-hospitalization; rehabilitation; communicating with other mental health professions — such as psychiatrists, psychologists and nurses who are more directly involved in the diagnosis, treatment and hospital care of the patient — concerning his social history and situation; and contributing generally to milieu therapy. In order to do this work a social worker requires a general training with sufficient knowledge of mental illness to perceive and understand the health problems of the patient. But his major skills and their focus concern the patient's social situation.
- 2) A psychiatric social worker is a general social worker employed in a mental health service to do the work described in 1), and also equipped, through supplementary in-service training in psychodiagnosis and psychotherapy, to treat certain patients individually or in groups (especially family groups) by means of counselling and psychotherapy. It is desirable but not necessary for the psychiatric social worker to have received extensive formal and practical training in psychodynamic psychology and psychopathology as part of his social work education. In any case, in order to perform this additional function supplementary in-service training is necessary usually under the direction of psychiatrists, and after formal training has been completed.
- 3) A psychiatric social worker is a social worker who has received specialized M.S.W. training in the diagnosis and treatment of emotionally disturbed persons by means of counselling and psychotherapy. Such a social worker would be equipped to share fully in the psychological aspects of the work of psychiatry (just as a clinical psychologist might) in a mental hospital, mental health clinic, or forensic service. He would not, however, be thoroughly trained in general social work and would not be as well equipped to perform the services enumerated under 1) as a social worker who was so trained.
- 4) In order to do justice to the realities of social work practice in Ontario, it is necessary to add a fourth concept. A social worker is a former nurse, teacher, or custodial officer in a training school, or a similar person, who has been employed to do the work of a trained social worker and who may receive some in-service training by an M.S.W. in psychiatric social work as described in 1). No doubt there are numerous skilled social workers generated for service in Ontario's institutions and agencies in this way, but the principal reason for the employment of

people so trained is the chronic shortage of trained social workers. A variant on this type of social worker is the graduate of a training program in social work at Ryerson Polytechnical Institute or at certain community colleges.¹⁶

There are psychiatric social workers of all four types practising in Ontario, although the third type is uncommon. Suffice it to say that the designation "psychiatric social worker" is intrinsically ambiguous, so that no simple and unequivocal definition can be given. Each of the first three categories fulfils a need for a specific kind of service or combination of services at a professional level. As might be expected, there has been some disagreement among social workers themselves concerning the nature of psychiatric social work, the training necessary for it, and its place in social work generally.

The Committee has observed in studying such disciplines as nursing, clinical psychology and social work that both within the discipline, and between the discipline and other disciplines, confusion, misunderstanding and disagreement about role and education are particularly noticeable where the service rendered by a discipline is to a considerable extent intangible in nature. Such services are, of course, more difficult to define and to evaluate than the more tangible services of, for example, health technicians. Moreover, possibly as a result, pay scales, working conditions and job satisfaction do not reach levels high enough to attract the number of people required to fill the existing jobs.

The Committee elsewhere in the Report¹⁷ has urged that a study of the roles of health care workers should be undertaken. In no area is such a study more difficult or more necessary than in the case of disciplines which are concerned in part with the state of mind of the patient, whether in mental or in physical ill health, and we urge that priority be given to role evaluation studies of such disciplines with a view to correcting as quickly as possible the conditions which give rise to manpower problems. In the case of social workers, these problems are already serious; and they appear likely to become steadily worse with the development of trends and programs, discussed elsewhere, which will produce substantial increases in the number of social workers required.

Manpower

In Ontario a variety of health institutions offer social work services. These services are organized in many different ways and provided by different types of personnel. Social workers are employed by general, mental and psychiatric hospitals, as well as by a variety of sanatoria, specialized health societies, group practices, community health centres and local departments of health. The employment of social workers by these institutions, however, has been rather limited. Of 215 general, convalescent and chronic hospitals in Ontario, fewer than one-quarter (fifty) report

¹⁶C. Hanly, *op. cit.*, pp. 376-378.

¹⁷See Chapter 10, Recommendation 70.

a social service department employing at least one social worker full time. Twenty-three of these employ a single social worker, thirteen employ two, and only fourteen employ more than two social workers on a full-time basis.¹⁸

The Hall Commission noted that in 1961 there were no hospitals in Canada with under 100 beds reporting a social service or social work department.¹⁹ Six years later, there were two hospitals in Ontario with under 100 beds, and five with under 200 beds that operate a social service department employing at least one social worker full time.

The overall social work personnel:bed ratio in Ontario for public general hospitals is 1:337. The three general hospitals in Ontario with the highest case-worker:bed ratios are the Ottawa General, Kingston General and Toronto General Hospitals; all three of these approximate a social worker:bed ratio of 1:70. On the other hand, several large hospitals have a social worker:bed ratio of less than 1:500. Ontario general hospitals reported twenty-five part-time social work employees, and these part-time workers have been included neither in the number of hospitals with social work departments, nor in the ratio of social workers to beds.

Some indication of the rate of increase in the employment of social workers in general hospitals over the last five years is given in the study by Landauer. Of the twenty-three hospitals sampled from among the group of hospitals employing at least one full-time social worker on December 31, 1966, nine reported no social workers employed full time on December 31, 1961. In the remaining fourteen hospitals, fifty-nine social workers were reported in 1961 and seventy-eight in 1966. The overall rate of growth in the number of social work employees in all twenty-three hospitals over the five-year period was 47 per cent. For the group of fourteen hospitals reporting a social service department established prior to December 31, 1961, the rate of growth for the five-year period was 30 per cent.

Given that only five hospitals in Ontario with fewer than 200 beds have a social service department employing at least one social service worker full time, and that several very large hospitals have only nominal social service departments with a social worker:bed ratio of less than 1:500, in contrast to the ratio of 1:70 in the hospitals with the highest ratios, the demand for personnel in this field is apt to grow. Several studies²⁰ have concluded that in terms of some indicators, there is a serious and growing shortage of trained medical social workers. As far as the immediate shortage of medical social workers is concerned, the Hall Commission said:

It is evident . . . that shortages of these personnel exist. In 1961 there were 51 full-time vacancies or 14 per cent of positions established for social workers unfilled in public, federal, and private hospitals. With the

¹⁸The following statistics are from M. Landauer, *op. cit.*, pp. 53-55, unless otherwise noted.

¹⁹*Report of the Royal Commission on Health Services*, Vol. II, *op. cit.*, p. 64.

²⁰See M. Landauer, *op. cit.*, pp. 62-64.

Commission's recommendations to establish home care and to treat more mental patients in general hospitals and in the community, there will be a still greater need for medical social workers both to help discharged patients and to assist their families. Methods must therefore be devised of overcoming existing and future shortages of these personnel.²¹

In 1967 there were approximately fifty vacancies (approximately 20 per cent) among the 210 budgeted positions for social workers in general hospitals. Similar, although slightly lower, percentages of unfilled budgeted positions apply in the mental and psychiatric hospitals. Several hospitals have indicated that for a variety of reasons they have been unable to secure the services of a qualified social worker, although they have attempted to do so and although the need for such a person in their hospital is clear. Most of these hospitals are in the northern regions of Ontario.

The extent of the shortage of social workers in community psychiatric services and in Department of Health psychiatric services in 1967 was determined by the Professional Services Branch, Mental Health Division, Department of Health. Their findings showed that there were 201 social workers in these services, of whom ninety-nine were in community psychiatric services and 192 in Department of Health services; nineteen were part time and 182 were full time. One hundred and thirty spent part of their time in inpatient services, 107 in outpatient services, 145 in adult services, and eighty-nine in child services.²² The sum of these figures is greater than the number of social workers because many of them, taken individually, worked in more than one service within a hospital or clinic.

At the time of the survey there were fifty-one vacancies for social workers in community psychiatric facilities, and forty-four vacancies for social workers in Department of Health facilities. The total shortage of social workers for existing positions, which should not be confused with needed posts in needed services, was ninety-five. To this may be added the vacancies for psychiatric social workers in the Department of Reform Institutions, private residential treatment centres for emotionally disturbed children and social agencies, all of which require social workers who are skilled in dealing with mental health problems.²³

Education

The Council of Social Work Education is an international body with affiliates throughout the United States and Canada. Its principal function is to establish and maintain standards of education and social work practice through the accreditation of schools for training of social workers in North American universities. It has been the task of the Council of Social Work Education to develop a basically uniform curriculum for the training of social workers in the schools of the

²¹*Report of the Royal Commission on Health Services*, Vol. II, *op. cit.*, p. 64.

²²C. Hanly, *op. cit.*, pp. 178-179.

²³*Ibid.*

United States and Canada. Two important parts of every training program are methodology and field work experience through which the student masters the practical skills of the profession. Some variation occurs in the way in which field work is introduced into the program at any given school. The concurrent plan or the block plan may be used. The concurrent plan integrates field work with ongoing formal lecturing and seminar work, whereas the block plan separates the field work as a special segment of the academic year, during which the students devote all their time to the field assignments.

The first of four elements which make up the nucleus of the curriculum of any school of social work is the study of individual human growth and the social environment; the second is social policy and services; the third, methodology; the fourth, field work. Methodology includes three specific topics: casework, group work and community organization. The individual student may concentrate on one or other of these methods. New thinking in social work is seeking to combine the methods, however, so that students will be competent to handle each. Also, administration and research are now being increasingly stressed, although they are not now major elements in the methods program.

Until very recently the only programs available for training in the field of social work in Ontario were Master of Social Work (M.S.W.) programs. For the academic year, 1965-1966, M.S.W. programs were available at the University of Toronto, University of Ottawa and Waterloo Lutheran University. Also a two-year certificate program was started at Ryerson Polytechnical Institute in September 1965. In the academic year 1968-1969 the following programs became available in addition to those mentioned above: a three-year undergraduate program in social work and an M.S.W. at Windsor University; a three-year baccalaureate program at Laurentian University in Sudbury; and two-year social service certificate courses at nine Colleges of Applied Arts and Technology (CAAT's) in the province. These colleges are Centennial, Humber, Seneca (all Metropolitan Toronto); Mohawk (Hamilton); Niagara (Welland); Fanshawe (London); Conestoga (Kitchener); Cambrian (Sudbury); and Confederation (Fort William). It is proposed that other social work programs will be established at McMaster, Queen's, Western and Carleton Universities in the next few years.

Master of Social Work Programs (M.S.W.)

The admission requirements for the M.S.W. programs are a B.A. degree with B average standing, with preference being given to those who have taken some social science subjects. All of the universities interview applicants personally. The University of Ottawa requires that applicants be between twenty-one and thirty-five years of age.

The M.S.W. program is of two years' duration and does not require a thesis. The basic courses are in the areas of social welfare policy and services, human behaviour and the social environment, and methods of social work practice (case-

work, group work and community organization). The program also includes training in administration, research and field work practice. The University of Toronto provides the field work concurrently with didactic courses, and the University of Ottawa provides it in "blocks" of time during or at the close of the academic years.

Baccalaureate Programs

There are two ways to enter the baccalaureate program offered at Windsor University. A student may enter the first year after completing grade thirteen with a 60 per cent overall average in seven subjects, including language and mathematics in grades eleven and twelve. Students with a 65 per cent average in six specific subjects in grade twelve may enrol in a preliminary year at Windsor. Students completing the program receive a general B.A. degree plus a Diploma of Social Work. The duration of the course is three academic years plus three twelve-week summer courses.

The course contains general arts subjects in the Faculty of Arts and Sciences including courses in humanities and social sciences. During the three summer sessions, social work theory and practice are studied. Students who already have a degree with an appropriate major may be admitted to the three summer sessions alone and receive the diploma of social work upon successful completion of the program. Although at the time of writing no details were available for Laurentian's baccalaureate program, the course content is likely to follow closely that at Windsor.

Ryerson's Program

Ryerson Polytechnical Institute requires that a student entering the two-year social welfare program have completed grade twelve of the five-year program with a 60 per cent overall average, and have taken physics, chemistry, biology and mathematics. A personal interview is required. The course titles at Ryerson are very similar to those of the university programs; however, there is no opportunity for individual research provided at Ryerson.

College of Applied Arts and Technology Programs

The prerequisite for the social service programs at all of the Colleges of Applied Arts and Technology is completion of grade twelve of any four or five-year program. The social service programs in each of the nine colleges where they are offered are very similar, but the director of each program has control over the curriculum and course preparation of his particular program. Since an objective of the colleges is to supply trained personnel to satisfy the manpower needs of the community in which the college is situated, the social service programs are adapted to best suit the area's particular requirements. For example, a college in an area where many residents were French-speaking would include a conversational French

course. If the social service students were expected to be employed in a home for disturbed children, the college would emphasize training in abnormal behaviour. As far as is known, none of the social services courses give special training in medical social work.

Graduates of these programs may find employment in public or private agencies, and may be required to spend a period assisting professional social workers under close supervision. As we mention in Chapter 26 (pp. 108-109), however, there has been uncertainty among employers as to the skills and performance of personnel trained in these new programs. The potential of such graduates has not yet been fully utilized, and their relationship to social work graduates from degree programs in the work setting still requires clarification. This is a problem which the Committee believes should be included in the study of the roles of health manpower recommended in Chapter 10 (see Recommendation 70).

Graduate Programs

The only graduate program available for social work in Ontario is a special diploma course offered at the University of Toronto, for which the prerequisite is an M.S.W. degree.²⁴ The course emphasizes theory and practice in one area of social work selected by the student from among casework, administration, research, staff development, advanced field instruction, and special projects. The student must spend a minimum of one academic session in full-time study. The program does not lead to a degree, but graduates are awarded a diploma.

Continuing Education

There are three different types of continuing education programs presently offered by the University of Toronto:

- 1) A course paralleling the M.S.W. program for full-time special students not proceeding to a degree. Mature persons with demonstrated performance in social service and with a minimum of grade thirteen plus four subjects at university level may be eligible to enrol in this course.
- 2) Advanced (non-degree diploma) studies for postgraduate students. Prerequisite is an M.S.W. or other appropriate preparation (see above).
- 3) Extension courses given during the regular academic year or in concentrated institutes in May and June. These are specifically planned to meet community needs and are directed to social workers in private agencies.

²⁴Graduate work means study beyond the M.S.W. degree, as the M.S.W. is the first degree given in social work at the University of Toronto.

The University of Windsor offers extension courses in evening and summer school with the same content and standards as those offered in regular day classes of the winter session.

The Ontario Association of Professional Social Workers offers lectures, study groups, seminars, institutes, and participation in local, provincial, national and international conferences.

We have already mentioned that the terms "medical" and "psychiatric" social work, although in common use, have usually been held by social work educators and administrators to refer only to the setting in which social work is carried on. Some of the most advanced practitioners in the medical and psychiatric settings, as well as some important social work educators, have, however, stressed the desirability — if not the practicality — of more specialized formal education in those areas of theory and method which are or could be developed to be of specific relevance for the practice of social work in one or another particular setting. There is a firm and growing demand from the health institutions themselves for the development by the schools of social work of specialized materials and sequences of courses for the practice of social work in medical and in psychiatric fields. In the fundamental reconsideration of the structure and content of the basic social work curricula now under way, renewed attention should be given to ensuring that students are exposed to material relating to medical and psychiatric social work.

The Committee does not question the continuation of the general approach to basic social work training. But there is an increased need for some kind of specialized education in the theory and skills for social work practice in health settings. It is the Committee's view that opportunities to specialize in medical and psychiatric social work should be made available after the student has completed her basic social work training. Hospitals require additional social workers, particularly in light of the increased utilization of outpatient facilities. As well, there is an increasing demand for such personnel to work in group practices and community health centres.²⁵ These institutions will require greater numbers of medical social workers who will provide better liaison between the patients and the community, and the group and the community.

Recommendations:

- 174** That increased resources be devoted to the production of more medical and psychiatric social workers. We note the experimentation being undertaken in developing different levels of social workers, both at the undergraduate and graduate (Bachelor's and Master's) level in university and at the diploma level in Colleges of Applied Arts and Technology, and recommend that programs continue to be developed at all levels to meet the needs of the community for varying levels of social service personnel.

²⁵See Chapter 29.

- 175** That medical and psychiatric social work be considered a specialty of general social work at the graduate level, and that programs in medical and psychiatric social work be made available for social workers wishing to pursue their studies in these areas.

The Committee has found evidence of a particular need for emphasis on promotion of the specialty of psychiatric social work, and believes that more social workers must be induced to enter this field. The increased utilization of outpatient facilities, particularly in the field of mental health, will call for greater numbers of psychiatric social workers who will play an important role in this type of organization.

Recommendation:

- 176** That programs should be established for social workers with either B.S.W. or M.S.W. degrees to take further training in psychiatric social work, and that such programs be made available through the existing schools of social work.

Regulation

At present, there is no system of certification or licensing of social workers in Ontario by a public agency, and thus there is no regulatory body to control the practice of the profession. The Ontario Association of Professional Social Workers carries out a certification program for its own members but has no authority to discipline any person practising the profession who is not an Association member. The Committee believes, however, that medical and psychiatric social workers should not be separated from the larger groups of social workers and that no public certification program for social workers in the health field is necessary at this time.

The Voluntary Association

The Ontario Association of Professional Social Workers was founded in 1964. According to the Letters Patent the purposes of the Association are as follows:

- 1) To promote and increase the knowledge, skill and proficiency of its members in the practice of social work.
- 2) To encourage and assist in the development of higher standards of practice among its members.
- 3) To facilitate action on issues relevant to social welfare and to the practice of social work throughout the province of Ontario.
- 4) To collect and preserve data and documents relating to social welfare and to furnish information and reports by the publication of bulletins, pamphlets and periodicals relating to social welfare and the proceedings of the Association.

- 5) To encourage and provide facilities for studies and research on social welfare.

Membership in the Association is not mandatory for the practice of social work in Ontario, although in some cases employers may require that their social work staff be members of the Association.

The Association may grant active membership to any person who has successfully completed a full two-year course of professional education in a recognized graduate school of social work. Membership is granted also to anyone who is already a member of the Canadian Association of Social Workers, which includes members who obtained their social work training as early as 1930 and whose qualifications may include a social work diploma, B.A. degree plus experience, or a Bachelor of Social Work degree. Under exceptional circumstances, other persons not meeting the present educational requirements may be admitted to the Association, although this occurs rarely. Included among such exceptions are students who are admitted to graduate schools of social work without having received a Bachelor's degree and are thus not eligible to receive a Master's degree (see p. 329). These "special" students, however, must complete a full two-year program of classroom and field work instruction. The Association also has a student membership which may be granted to any person who is a full-time student enrolled in a recognized school of social work.

The total membership in the Association for 1965 (the first year for which figures were provided to the Committee) was 1,006. Of this number, forty-five were student members and forty-five were retired or not in practice at that time. The 1968 membership total was 1,208, of whom 112 were student members and 122 were not practising.

The Association is governed by a Board of Directors composed of twenty-five elected members, and an Executive Committee which is appointed by the Board. There are also five special committees of the Board: Committee on Social Issues, Committee of Social Workers in the Health Field, Committee on Salary Standards, Committee on Education for Social Work, and Committee re Licensing and Regulation of Practice.

The work of the Salary Standards Committee over the years probably has contributed to a substantial increase in salaries. The association reviews salary levels about every two years, and its recommendations are circulated to members and to employing agencies. Working conditions in general have improved through such recommendations made in relation to personnel policies.

The Association reports that it has close liaison with the schools of social work in the province, as well as with the Department of Education and Department of University Affairs.²⁶ The Association plays an active role in recruitment

²⁶Ontario Association of Professional Social Workers, reply to Questionnaire "B", Committee on the Healing Arts.

to the profession by discussing social work as a career with high school students, teachers and university undergraduates. Through the Canadian Association of Social Workers, representation was made to the National Department of Health and Welfare for financial assistance to social work students. This resulted in the Training Grants Program, which provides such assistance to those wanting professional training in social work.

Chapter 15 Chiropody

Definitions

Two terms, chiropody and podiatry, have been used to designate the practice of diagnosis and treatment of foot disorders. Chiropody is the original term used at the beginning of the practice over 100 years ago; it is the term used by those trained in Great Britain; and it is the term utilized in the legislation controlling chiropody in Ontario.¹ Podiatry was introduced as a more accurate term approximately fifty years ago, since chiropody actually means treatment of the hand and foot. The terms have been and are used interchangeably, but podiatry has come to connote a practice of larger scope, a longer course of training, and more prerequisite education. Podiatry is the term used in the United States and, as most of the persons in Ontario engaged in the treatment of foot disorders have been trained there, they too tend to use the term. In this chapter, however, we shall employ the term chiropody, since this is the term utilized in the present Ontario Chiropody Act.

Foot care is an important aspect of health care, particularly to the poor and elderly. In Ontario it has been neglected; there is only one chiropodist per 100,000 population, compared with one per 30,000 in the United States, and one per 20,000 in the United Kingdom; there are no educational facilities for their training, and because of the qualifications required for licensing, British-trained chiropodists are virtually excluded from practice in the province.

Chiropody is widely accepted as a health service in North America, but chiropodists do not enjoy the status or privileges of the major health professions. In a few hospitals in Ontario they have been permitted to assist with podiatric care but do not have hospital privileges. They are not trained in universities, and one can object to the fact that their education in the basic sciences is not as strong as it might be, particularly if they were allowed the same scope of practice as in the United States.

Since chiropodists have come to Ontario mainly from schools in the United States, the quality of their education and, therefore, the merits of their practice are difficult to assess. Even physicians are ambivalent as to whether chiropody should be regarded as a paramedical occupation or a profession. Physicians and chiropodists disagree on the definition of a chiropodist's scope of practice, and the ambiguous wording of the Chiropody Act has complicated the matter.

¹R.S.O. 1960, c. 57.

There has been much controversy over the merits of the practice of chiropody, and the extent of Ontario's needs regarding foot care is largely unassessed. We have looked in some detail at both chiropody as practised in England and podiatry as practised in the United States, as well as the existing situation in Ontario.

History and Legislation

Conditions of the foot have been studied and treated since ancient times, but the present-day profession of chiropody is less than 150 years old. It is commonly believed that chiropody came into existence and developed as a distinct discipline apart from the medical profession because the general medical practitioner lacked interest in treating disorders of the foot.² The American Medical Association's Judicial Council has officially described chiropody as "A limited field, considered not important enough for a doctor of medicine to attend, and therefore too often neglected".³

In the late nineteenth century in Ontario, foot care traditionally was patterned along the lines of British chiropody since the majority of practitioners received their education in Britain. By the turn of the century, as schools of chiropody were established in the United States, residents of Ontario tended to seek training there.

Although there were a number of persons in North America practising chiropody after the middle of the nineteenth century, it was not until the end of that century that attempts were made to obtain legal recognition for the practice and to organize a professional group of chiropodists. In 1895 chiropodists in the state of New York founded the Pedic Society of New York, which was the first professional organization of chiropodists in the world. As a result of the efforts of this Society, the first legislation governing the practice of chiropody was passed in New York State in 1895. Other state societies were formed after 1900 and they too sought legislation governing their practice. In the United States the first chiropody journal, *Pedic Items*, was published in 1907, and the National Association of Chiropodists was organized in 1912.⁴

The first modern school of chiropody in North America, the New York Chiropody School, was organized in 1912, with a medical doctor serving as its first president. After this school received a provisional charter from the State of New York in 1917, it became affiliated with Long Island University.

Efforts of both chiropodists and physicians encouraged the establishment of schools of chiropody in other states. The California College of Chiropody was founded in 1914 and was the first institution to grant a Doctor of Surgical

²The Board of Regents of Chiropody, Brief to the Committee on the Healing Arts, 1967, p. 1.

³*Ibid.*, p. 2.

⁴The historical notes on chiropody in the United States are drawn from Charles E. Krauz, "A Brief History of Chiropody in America," *The Journal of the Canadian Association of Chiropodists*, January 1955, pp. 16-17; June 1955, pp. 10-11; and October 1955, p. 20.

Chiropody degree. A Chiropody School established at Temple University in 1915 was the first school to be formally affiliated with a recognized university. Several small chiropody schools in Chicago united and formed the Illinois College of Chiropody in 1916, which has the largest number of graduates of any chiropody college. In that same year the Ohio College of Chiropody was founded in Cleveland, and in 1931 the Chicago College of Chiropody was established.

The entrance requirements and the length of instruction in these colleges gradually increased over the years. In 1916 two years of high school were required for admittance to a chiropody college. This was increased to three years in 1920, and to four years in 1923; one year of university was required in the 1940's; and today the prerequisite is two years of university. The standard course of instruction in chiropody colleges was one year in 1916, two years in 1924, three years in 1932, and in 1937 it was raised to the present level of four years. Details of both the courses are given later in this chapter.

As late as the 1920's there were no licensing requirements or regulations governing the practice of chiropody in Ontario and anyone with or without formal training could practise. There were perhaps one-half dozen formally trained chiropodists in Ontario at the time.⁵ In 1925 the practice of chiropody came under the regulation of the Drugless Practitioners Act. By the 1940's American-trained chiropodists, calling themselves podiatrists, had become the majority in Ontario and succeeded in having new legislation passed, the Chiropody Act, in 1944.

The Chiropody Act established the Board of Regents of Chiropody, which has five members appointed by the Lieutenant Governor in Council for two years and eligible for reappointment. The Board is responsible for administering the Chiropody Act and the Regulations under the Act. Its major functions include: 1) specifying requirements for registering practitioners; 2) specifying guidelines for appropriate behaviour, and disciplining practitioners for misconduct; and 3) prescribing qualifications or standards for the training of chiropodists and approving professional schools.

In 1950 and again in 1955 the Regulations under the Chiropody Act were revised, and the educational requirements for licensing were extended in such a way as to virtually exclude British chiropodists from practising in Ontario; the only exceptions were those practitioners permitted to continue to practise under a "grandfather clause". In 1960 the Act was again revised, but with no major changes, and the barriers to the entry of British chiropodists remained.

While the educational requirements for licensing in Ontario effectively limit licensure to those who are graduates of schools of podiatry in the United States, the scope of practice which appears to be intended by the statutes of Ontario is considerably smaller than that permitted in many states of the United States, and certainly is smaller than that to which podiatrists trained in the United States

⁵"Dr. Norman Foote . . . and Podiatry in Canada", *The Canadian Journal of Podiatric Medicine*, Vol. 1, No. 1, July 1963, pp. 2-3.

aspire. We comment on this matter at greater length below but note here that the consequence of the above circumstances has been to limit sharply the numbers practising chiropody in Ontario. On the one hand, Ontario is not an attractive place for graduates of schools in the United States; their practice is limited to a level below what their training intends. On the other hand, the British chiropodist is excluded.

Manpower

There are no reliable figures on the number of chiropodists who have practised in Ontario in the first half of this century. In 1950, however, there were sixty-seven registered chiropodists. This figure dropped to sixty-six in 1960 and rose to sixty-nine in 1967. This latter figure includes seven British-trained chiropodists who entered practice before 1950. Most (90 per cent) of the chiropodists today are male. Approximately one-fourth (27 per cent) of the chiropodists in Ontario are thirty-nine years of age or younger; 32 per cent are forty to forty-nine years old; 19 per cent are fifty to fifty-nine years old; and 23 per cent are sixty years of age or older. The average age group is forty to forty-nine years; this is the same average age group for chiropodists in the United States.⁶

There are no figures available to indicate definitely the rate of turnover in the profession. However, most of the chiropodists practising in Ontario have practised only in this province. One-third of them have practised in the province for over twenty years; 37 per cent have practised in the province between ten and twenty years; and the remaining 31 per cent have practised in Ontario for ten years or less.⁷

A large majority (almost 72 per cent) practise in cities of 100,000 population or larger; 21 per cent practise in cities of 50,000 to 100,000 population; and only 8 per cent practise in cities of fewer than 50,000 people.⁸

The American Medical Association reported that the Special Commission on the Status of Podiatry Education in the U.S.A. found that there were approximately 7,600 chiropodists practising in the U.S.A. in 1964, or one chiropodist for every 23,000 people. The number of practitioners per state ranges from 1,600 in New York to ten in North Dakota. The Commission's report states that as much as 80 per cent of the American population have suffered or are suffering from some sort of foot ailment, and that more than 85 per cent of elderly people are afflicted with foot disorders.⁹

⁶Lloyd E. Bluch, "1964 Survey of the Podiatry Profession. 1. The Podiatrists: Distribution, Education, Organizational Relationships", *Journal of the American Podiatry Association*, Vol. 55, No. 3, March 1965.

⁷*Podiatry in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

⁸*Ibid.*

⁹American Medical Association, *Review of the Current Status of Podiatry and Chiropody*, Chicago, 1964, p. 9.

The only information available on the number of chiropodists in Britain is the total of registrants under the Chiropody Board in 1964, which was 4,300. It is not compulsory that chiropodists in Britain be registered to practise, except for those practitioners employed in the National Health Service.

Assuming that the incidence of foot problems in Ontario is similar to that of the British and Americans, there is evidence of considerable need for the supply of chiropodists in the province to be increased. At present there is only one practitioner per 100,000 people in Ontario. Chiropodists have expressed the view, however, that unless the legislation with respect to the scope of practice of chiropody were changed, there would be little or no incentive for more American-trained practitioners to establish practice in this province.¹⁰

Education

Up to the present time there has been no educational institution of chiropody in Canada. The majority of those chiropodists practising in Ontario are graduates of American colleges. There are the few British-trained chiropodists who obtained registration under the grandfather clause of the Chiropody Act, 1944; however, since 1950 no more British-trained chiropodists have been able to qualify to practise in Ontario. Any such chiropodists wishing to be licensed would have to attend an approved school of chiropody for at least a further year, and few would qualify for entrance to the schools in the United States, the only ones accredited by the Ontario Board.

There are now five chiropody colleges operating in the U.S.A.:

- 1) M. J. Lewi College of Podiatry, New York City, New York.
- 2) Illinois College of Chiropody and Foot Surgery, Chicago, Illinois.
- 3) California Podiatry College, San Francisco, California.
- 4) Ohio College of Chiropody, Cleveland, Ohio.
- 5) Pennsylvania College of Podiatry, Philadelphia, Pennsylvania.

A sixth college, the Chicago College of Chiropody and Pedic Surgery, Chicago, Illinois, ceased operating after 1963, and the Pennsylvania College has opened since that time. None of these chiropody colleges is affiliated with a university or medical school.

Accreditation falls into two main categories: accreditation by the discipline itself, and accreditation by independent bodies or commissions. The American chiropody colleges are accredited by the American Podiatry Association and the Canadian Podiatry Association. In the United States chiropody colleges are accredited by the Department of Health, Education and Welfare of the federal

¹⁰Ontario Podiatry Association, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, pp. 1421-1423.

government, which allocates public funds to schools training various categories of health personnel. Periodic inspections of the colleges are made by the Ontario Podiatry Association.

The education requirements for admission to American chiropody programs have increased considerably since the first college was established in 1911. The Council on Education of the American Podiatry Association now requires all accredited colleges to include among their admission standards sixty semester hours — i.e. two years of baccalaureate credit in certain subjects. A survey of chiropodists in the United States conducted by the American Podiatry Association in 1964 revealed that the average number of years of pre-professional college education attained by practitioners was 2.0 years, compared with 1.8 years for 1960. The American colleges will accept the Ontario grade thirteen as the equivalent of one pre-chiropody year of college, with the applicant required to complete another college year.

The 1964 American Medical Association review of chiropody revealed that thirty-five states require applicants for chiropody licensure to have completed only four years of high school or be high school graduates; ten states require two years of pre-professional college work; and twenty-one states require one year of pre-professional college work. A few statutes prescribe the subjects which the applicant must have covered in this college work. Ontario regulations do not require any pre-professional university education.

The five existing colleges in the United States all have four-year programs. A precise comparison of the curricula of the four chiropody schools is not feasible because of variation in course titles offered. The programs, however, consist of approximately 4,200 hours, of which some 3,000 are didactic and 1,200 are clinical, as follows:

Anatomy, physiology, pathology	1,100 hours
Microbiology and biochemistry	200 hours
Surgery and anaesthesiology	300 hours
Medicine	600 hours

The specialized podiatric subjects include:

Podiatry therapeutics, physical podiatry, psychosomatic podiatry, podiatric orthopaedics, podopediatrics, podiatric roentgenology, physiotherapy and clinic	2,000 hours
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The Ontario Board has reported that medical and basic science departments of the chiropody colleges are headed, in the main, by physicians. In 1960 the faculties of the five chiropody colleges operating at that time included 124 Doctors of Surgical Chiropody or Podiatry, and seventy-six Doctors of Medicine.¹¹

¹¹American Medical Association, *Review of the Current Status of Podiatry and Chiropody*, *op. cit.*, p. 3.

The 1966-1967 calendar for the Ohio College of Podiatry showed that of a faculty of sixty-six, twenty-two members were physicians. In addition, the college had eight medical "consultants". Thus, fewer than one half of the teaching personnel were physicians.

There are eight schools of chiropody in Britain: five in England — the Chelsea School (London), London Foot Hospital School, the Birmingham General Dispensary School, the Manchester Foot Hospital and School, and the Salford School, Salford Technical College; two in Scotland — the Edinburgh Foot Clinic and School, and the Glasgow Foot Clinic and School; as well as the Cardiff School in Wales. There is a Chiropodists' Board, which is one of eight boards set up under the Professions Supplementary to Medicine Act, 1960. It inspects courses of training and is responsible for conducting the examinations. The Board does not recognize for purposes of registration any existing correspondence courses in chiropody.

The requirements for entrance to the British chiropody programs include an age limitation of seventeen years and over. An applicant must have gained the General Certificate of Education or its equivalent with passes in four subjects. Those applicants who have gained a pass at the Advanced (or Higher) level in any one of the first year science subjects (biology, chemistry or physics) may be granted an exemption from the examinations in such subjects.

The British courses are three-year programs. The available information did not give a detailed breakdown of the hours spent on each subject, but the subjects included are:

Anatomy and physiology

Elementary pathology and bacteriology

Medicine in relation to disorders of the lower limb

Dermatology

Surgery in relation to disorders of the lower limb

(indications for surgical intervention of the foot are fully covered and the importance of post-operative care to which the chiropodist may contribute is also stressed)

Podology

Therapeutics (includes elementary pharmacy and a detailed study of drugs for external medicine)

There is much less representation of the medical profession on the faculties of British chiropody colleges than in the United States. In 1966 most of the British colleges had a faculty of approximately twenty members, and in most cases there was only one physician on each faculty.

All the examinations in chiropody are conducted by external examiners appointed by the Education and Examinations Committee of the Society of

Chiropodists. The external examiners in medical subjects are selected from a panel approved by the Royal College of Physicians and the Royal College of Surgeons. These external examiners set and mark papers in conjunction with other internal examiners for each school, the latter being appointed by the schools concerned.¹²

Role of the Chiropodist

Because of the evident differences in the education of chiropodists in Britain and the United States, there are wide variations in patterns of practice in the two countries. In effect, British chiropodists see their role as supplementary to medicine; there is a sense in which they may be regarded as paramedical personnel, although they do not always practise on referral from physicians. In contrast, American podiatrists have a much wider scope of practice based on their more extensive education. Consequently, they regard themselves as independent professionals and strive constantly, in Ontario as well as in the United States, for full recognition and status as professional men. This contrast makes it necessary for us to examine in some detail the variations in the perception of role and the legal status of practitioners in the various jurisdictions.

According to the Ontario Chiropody Act, a "chiropodist" or podiatrist

... means a person, other than a duly qualified medical practitioner, who practises or advertises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human foot.¹³

The Act states that a chiropodist is not permitted "to administer a drug internally or to prescribe a drug for use internally, to administer an anaesthetic other than a substance applied externally to the skin; or to practise medicine, surgery or midwifery".¹⁴ But the addition of the proviso, "but nothing in this Act or the regulations prevents the treatment by a registered chiropodist of morbid conditions of the nails and skin and the resulting minor morbid conditions of the subcutaneous tissues of the human foot",¹⁵ causes ambiguity; it is difficult to define exactly what a chiropodist is permitted to do in this province.

A recent judgment of the Ontario Court of Appeal illustrates the ambiguity of the present limitations of the practice of chiropody. The College of Physicians and Surgeons prosecuted a podiatrist, one Foote, for contravening section 51 of the Ontario Medical Act,¹⁶ which prohibits any person not registered under the Act from practising "medicine, surgery or midwifery for hire, gain or hope of reward" The issue in the Foote case was whether a chiropodist who had performed what were found to be surgical procedures in the removal of callused

¹²*Chiropody—Regulation and Syllabus for Training*, Society of Chiropodists, London, England, 1965, p. 2.

¹³R.S.O. 1960, c. 54, s. 1.

¹⁴*Ibid.*, s. 4.

¹⁵*Ibid.*

¹⁶R.S.O. 1960, c. 234, as amended by 1962-63, c. 80.

flesh from one patient, in the treatment of a condition in another patient caused by ingrown toenails, and in the removal of a foreign object from the foot of a third patient, all of which procedures were preceded by the administration of a local anaesthetic by means of a hypodermic syringe, practised surgery for gain within the meaning of section 51. As already indicated, the Chiropody Act provides that nothing in the Act or the regulations shall authorize any chiropodist,

- (a) to administer any drug internally or to prescribe any drug for use internally,
- (b) to administer an anaesthetic other than a substance applied externally to the skin; or
- (c) to practise medicine, surgery or midwifery¹⁷

but nothing contained in the Act shall prevent the treatment by a registered chiropodist of the morbid conditions of the nails and skin and resulting minor morbid conditions of the subcutaneous tissues of the human foot.

The chiropodist was convicted by the magistrate, but on appeal to the county court judge, counsel for the respondent (i.e., the prosecution) agreed that the treatment of the first two patients was of minor morbid conditions of the skin; these treatments were permitted by section 4 of the Chiropody Act, and it was held that the Act must be interpreted so as not to prohibit whatever is necessary, even if that be the use of hypodermic syringes to administer local anaesthetics, to make the permitted treatment a painless one. Accordingly, the judgment was that the acts of the chiropodist with respect to the first two patients did not amount to violations of the Medical Act.¹⁸ As to the third patient, it was agreed that the removal of the foreign object was not a treatment of a morbid condition of the skin. As this act was but an isolated act, however, it could not be said, on the basis of the decided authorities, that the act constituted "practising" as charged. On the authorities, the word "practise" connotes repetition. In this connection the reader is referred to the discussion of the judicial interpretation of the term "practise" in professional practice statutes. (See Chapter 25.)

The Ontario Court of Appeal's dismissal of an appeal from the judgment of the county court judge in the Foote case was understandably taken by the chiropodists as a vindication of their interpretation of the practice rights conferred on them by the Chiropody Act. The chiropodists subsequently brought an action in the Supreme Court of Ontario in an attempt to have their view of their right to prescribe drugs confirmed. Section 2(d) of the Pharmacy Act¹⁹ provides that "nothing in that Act interferes with the rights or privileges conferred upon a chiropodist by the Chiropody Act". What the chiropodists sought in their action was, first, a declaration that section 2(d) of the Pharmacy Act allows chiropodists

¹⁷R.S.O. 1960, c. 54, s. 4.

¹⁸*Regina v. Foote*, Judge H. Deyman of the County Court of the County of Peterborough, July 12, 1966.

¹⁹R.S.O. 1960, c. 295.

to prescribe, and that a pharmacist is permitted to fill a chiroprapist's prescription; and second, an order compelling the Ontario College of Pharmacy 1) to retract a newsletter to pharmacists advising them to the contrary and 2) to advise pharmacists that they are authorized to fill chiroprapists' prescriptions.

On appeal from the judgment of Henderson J. dismissing the chiroprapists' action, the Ontario Court of Appeal held that section 4 of the Chiroprapody Act (providing that nothing in the Act or the regulations prevented the treatment by a registered chiroprapist of morbid conditions of the nails and skin and the resulting minor morbid conditions of the subcutaneous tissues of the human foot) conferred upon a registered chiroprapist a right, albeit a limited one, to legally prescribe certain drugs and a corresponding right upon pharmacists to honour these prescriptions. Accordingly the Court granted a declaration that "a registered chiroprapist is permitted to prescribe and a pharmacist is permitted to dispense on a prescription of such chiroprapist those drugs enumerated in Schedule 'C' to the Pharmacy Act . . . such as are necessary to treat the external morbid conditions of the nails and skin and the resulting minor morbid conditions of the subcutaneous tissues of the human foot, as provided for in section 4 of The Chiroprapody Act" ²⁰

It will be seen that the decision of the Court of Appeal leaves undetermined the key issues of the meaning of "minor morbid conditions" and "subcutaneous tissues"; and, most important, neglects to state which drugs specified in Schedule C of the Pharmacy Act are necessary to the external treatment of morbid conditions of the nails and skin and the resulting minor morbid conditions of the subcutaneous tissues of the human foot.

The Ontario Podiatry Association states emphatically that, "podiatrists are not auxiliary to medicine, are not drugless practitioners, and are not para-medical". ²¹ Most spokesmen for organized medicine in North America do not accept this view.

In June 1960, the House of Delegates of the American Medical Association adopted the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services. The report stated that:

Such statutes relating to services which involve the diagnosis or treatment of nervous, mental or physical illnesses or disorders of individual patients should require such services to be performed under the direct supervision of or in genuine collaboration with a qualified physician. ²²

The Ontario College of Physicians and Surgeons does not consider chiroprapists to be qualified to make a differential diagnosis, practise surgery, or prescribe drugs;

²⁰*Laine et al. v. Caplin et al.*, Ontario Court of Appeal, November 28, 1969, reversing the judgment of Henderson J., September 24, 1969.

²¹Ontario Podiatry Association, Brief to the Committee on the Healing Arts, 1967, p. 2.

²²American Medical Association, *Review of the Current Status of Podiatry and Chiroprapody*, Chicago, 1964, p. 7.

and it asks that the limits of the practice of chiropody be defined more precisely than they now are, so that there will be no doubts as to what chiropodists are permitted to do.²³ A study conducted for the Committee reports that chiropodists themselves are confused about whether or not they are prohibited by law from administering drugs or practising surgery.²⁴

Although chiropodists in Ontario claim they are trained to treat any condition of the foot except those which require amputation, the conditions which they treat most often are corns, calluses, warts, ingrown toenails, ingrown hairs, fallen arches, removal of foreign objects, aching feet, hammer toes, bunions, fungi, arthritis, bone fractures, and disorders of the foot related to diabetes. Some chiropodists have indicated that as many as 70 per cent of their cases involve treating corns and calluses.²⁵

Diagnosis

Chiropodists claim that they are competent to diagnose; for they are trained to do so, and their background in the basic sciences prepares them to recognize those conditions which extend beyond their scope of practice and should be referred. The Board of Regents has informed the Committee that chiropodists cannot treat without diagnosis and that they must have access to x-ray and laboratory facilities in order to do so. Actually 80 per cent of chiropodists in the province use x-rays in making a diagnosis, but do so for only a small percentage of their patients.²⁶

Seventy-five per cent of the chiropodists reported that they have laboratory work done, such as urine, blood and tissue analysis, in conjunction with their practice. Only 10 per cent of these persons do all their own laboratory work and the others send at least some of it to outside laboratories. Over a quarter of the chiropodists reported that laboratory facilities in the local hospitals or the provincial laboratories were not available to them.²⁷ Some indicated that hospital laboratories were denied to them at some times and not at others.

The Board of Regents has pointed out that the question of acceptance or non-acceptance by the Public Health Laboratory Service of the Ontario Department of Health of specimens submitted by chiropodists for tissue study is a serious potential and unnecessary risk to the public. The laboratory accepts some types of specimens and refuses others, and the Board has requested that this issue be clarified.

In many parts of the United States, chiropodists are permitted to conduct the preliminary diagnosis of their patients, except in the hospital clinics where every patient is given a medical examination. The 1964 survey of chiropody conducted

²³College of Physicians and Surgeons of Ontario, Brief to the Committee on the Healing Arts, Part II, 1967, pp. 29 and 47.

²⁴*Podiatry in Ontario, op. cit.*

²⁵*Ibid.*

²⁶*Ibid.*

²⁷*Ibid.*

by the American Podiatry Association revealed that about 87 per cent of the chiropodists concerned used a roentgenogram made with x-rays as an aid in diagnosing certain foot conditions.²⁸

Chiropodists in Britain make their diagnosis without medical supervision. They do not use x-rays in their practice,²⁹ and in the examination syllabus set out by the Society of Chiropodists in Britain, radiography is not included as one of the areas of study for chiropody schools.³⁰

Drugs and Anaesthetics

The current legislation does not define clearly the position of chiropodists in Ontario with respect to prescription of drugs and administration of anaesthetics, and the recent judgment of the Ontario Court of Appeal discussed on page 343 still leaves unclear the scope of prescription allowed to the chiropodist.

A submission made to the Committee by the Ontario College of Pharmacy reveals that the result of the Foote case confused the College as to the authority of the pharmacist and the chiropodist in respect to prescriptions. The pharmacists also want the language of section 4 of the Chiropody Act clarified.³¹

The College of Physicians and Surgeons of Ontario considers the topical anaesthetic applied to the skin surface to be sufficient for the scope of work which chiropodists are entitled to do according to the College's interpretation of the Chiropody Act. It said that if any procedures are painful, they are "minimally" so, and the discomfort would be more than offset by the hazard of using local injections for the procedures involving the skin.³² The College does not feel that the chiropodists have had sufficient training to give local anaesthetics by injection, especially since chiropodists do not have the training or equipment for resuscitation and since there are no tests which will indicate the patient's reaction until the anaesthetic has been applied.³³

The Ontario Podiatry Association reported that, if they could, they would use barbiturates for pre-operative sedation of a patient and narcotics for post-operative analgesia.³⁴

²⁸"Report of Survey", *Journal of the American Podiatry Association*, Vol. 55, No. 3, March 1965, p. 19.

²⁹The Board of Regents of Chiropody, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, pp. 1357-1359.

³⁰*Reports of the Committees on Medical Auxiliaries*, Ministry of Health, Department of Health for Scotland, His Majesty's Stationery Office, London, 1951, Appendix IV.

³¹Ontario College of Pharmacy, Supplementary Submission to the Committee on the Healing Arts, 1967, p. 1.

³²College of Physicians and Surgeons of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, February 19, 1968, p. 30.

³³*Ibid.*, pp. 20-21.

³⁴Ontario Podiatry Association, Transcript of the Hearings of the Committee on the Healing Arts, October 23, 1967, p. 35.

In the United States, training programs for chiropody devote a considerable number of hours (about 200) to pharmacology, and most of the teachers in this field are medical men. But the picture regarding the status of chiropodists' use of pharmaceuticals is not at all clear. Conflicting information provided by the American Medical Association and the American Podiatry Association makes it difficult to gain an accurate picture. According to the 1964 American Medical Association's Review of the Status of Podiatry in the U.S.A., forty-five state statutes in their definitions of podiatry or chiropody specifically limit podiatrists to the use of local anaesthetics. Some of the state definitions also authorize the use of particular drugs or place restrictions on the use of other drugs. The American Medical Association points out that in order to determine the status of that authority in a particular state it is necessary to check not only the podiatry licensure law, but also the state pharmacy law, the state food and drug laws, the state narcotics acts, and any other statutes, court decisions, opinions of the Attorney General and regulations of government. This determination was not made in the review of podiatry conducted by the American Medical Association.³⁵

The above information is not in agreement with that of a submission of the Board of Regents of Chiropody entitled, "The Pharmaceutical Status of Podiatry in the U.S.A.", which was issued by the American Podiatry Association, November 4, 1964. This submission shows that with the exception of only twelve states, podiatrists are given full right of prescription. Only seven states stipulate limitation to local anaesthetics.³⁶

The British training for chiropodists does not include the prescription of drugs or use of anaesthetics. As outlined in the section on education, the British courses introduce the students to elementary pharmacy and include a study of drugs for external medicine only.

Surgery

The existing legislation allows sufficient latitude in interpretation as to render it difficult to decide to what degree chiropodists may practise what is, in effect, surgery. The chiropodists themselves had difficulty explaining to the Committee how they would differentiate between major and minor surgery.³⁷ The Board holds that "non-surgical treatment of structures and tissues of the lower leg" is included because it is often necessary to treat a calf muscle or other muscles of the lower leg, as they govern the function of the foot.³⁸ The Association maintains that

³⁵American Medical Association, *Review of the Current Status of Podiatry and Chiropody*, *op. cit.*, p. 4.

³⁶The Board of Regents of Chiropody, Supplementary Brief to the Committee on the Healing Arts, 1967, Appendix A.

³⁷The Board of Regents of Chiropody, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, pp. 1333-1334, also 1353-1354.

³⁸*Ibid.*, pp. 1333-1334.

chiropodists perform some surgical procedures, but that there is self-limitation through competence and available facilities.³⁹

The primary limitation placed on chiropodists in the American statutes is with respect to surgery. Thirty-eight state laws specifically contain a prohibition against amputation; in addition, eighteen states set forth other specific limitations on the extent of surgery that chiropodists may perform. The statute with respect to chiropody in New Mexico gives a description typical of the more restrictive surgical practice in these eighteen states:

The practice of minor surgery shall not permit operations upon bones, muscles or tendons of the feet or any other parts of the body except operations for minor deformities of mechanical and functional nature, including structures superficial to the deep fascia and including all structure of the terminal phalanges.⁴⁰

To be eligible to practise surgery in an American hospital a chiropodist must have a Fellowship of the College of Foot Surgeons. To attain this certification a chiropodist must first have completed a specified number of hours of postgraduate work in surgery. There is only one chiropodist in Ontario who has attained a Fellowship of the College of Foot Surgeons.⁴¹

There are no specified restrictions on the practice of surgery in a chiropodist's own office, other than those limitations described in the statutes for the individual states. We have been advised that only one per cent of the daily practice of chiropody is in the field of surgery for all of the United States, although a few chiropodists perform surgery exclusively.⁴²

As required by the Joint Commission on Accreditation of Hospitals, a chiropodist must be under the supervision of a physician when practising surgery in hospitals in the United States. The nature and degree of the physician's participation depends on the nature of the particular case and the general policy of that hospital governing the relationship between the physician and chiropodist.

The British training for chiropodists introduces students only to general surgical principles and to those conditions which may require the surgeon's attention. The chiropodists learn the indications and contra-indications for surgical intervention, as well as the need, where applicable, for post-operative care by the chiropodist.⁴³

³⁹Ontario Podiatry Association, Transcript of the Hearings of the Committee on the Healing Arts, October 23, 1967, p. 51.

⁴⁰American Medical Association, *Review of the Current Status of Podiatry and Chiropody*, *op. cit.*, p. 21.

⁴¹Ontario Podiatry Association, Transcript of the Hearings of the Committee on the Healing Arts, October 23, 1967, p. 65.

⁴²Ontario Podiatry Association, Transcript of the Hearings of the Committee on the Healing Arts, October 23, 1967, p. 63.

⁴³*Chiropody — Regulations and syllabus for Training*, *op. cit.*, p. 4.

Recommendations Regarding Role

The Committee regards chiropody primarily as the British regard it, as supplementary to medicine. In this field, as in others, we regard the proliferation of professionalization as unnecessary, socially disadvantageous, and likely to decrease rather than increase cooperation within the health care system. The British pattern of chiropody seems to us to fit most efficiently into our concept of the health care system for Ontario.

We are not persuaded that the chiropodists should have their scope of practice expanded to include surgery involving the subcutaneous tissues, or the use of drugs other than topical anaesthetics. We believe that the existing educational programs in American podiatric schools tend to overtrain their graduates, at least for Ontario's needs. These programs are intended to enable the chiropodist to perform relatively sophisticated procedures, including surgery. Very little of this surgical training is put to use (as we have seen, in America approximately only one per cent of the daily practice is in the field of surgery). Also, we believe that the services required of a chiropodist which would not be provided by physicians can be provided by British-type chiropodists trained in a three-year educational period.

We realize that limiting the practice of chiropody to what is now intended by the Act restricts it to a scope less than that aspired to by the podiatrists trained in the United States. We comment at length in Chapter 25 on the interpretation given by the Board of Chiropody to what chiropodists should do. They frankly see their appropriate scope of practice as being sufficiently broad that the British-trained practitioner does not qualify for the practice of chiropody in Ontario. This interpretation has limited the numbers admitted to practice in this province. We believe that in the long run, in order to obtain the numbers of properly qualified practitioners we require for foot care at any reasonable cost, it is necessary that chiropodists trained to the level of the British practitioner be permitted to practice in Ontario. Further, given the incidence of foot problems, particularly among the elderly, we believe that this course offers the best means of providing foot care sufficient to meet Ontario's needs.

Moreover, we see no reason why chiropodists should have their practice so sharply limited that they could practise only under medical supervision or on referral from a physician. Such restrictions would seem to us excessive. We have heard little or no evidence that physicians generally are either willing or able to provide much foot care, or that chiropodists fail to refer patients to physicians when the patient's condition is beyond the chiropodist's normal scope of practice. Thus, while we do not regard chiropodists as fully professional personnel, we see no reason to prevent them from carrying on as relatively independent practitioners. Accordingly, the recommendations which follow are designed not only to establish educational facilities for chiropodists in Ontario on the British model, and to restrict the practice of chiropody to that intended by the present Chiropody Act, but also to assure the provision of high quality foot care.

Recommendations:

- 177** That the existing Chiropody Act be repealed and new legislation enacted, to permit the practice of chiropodists in Ontario with training similar to that received by chiropodists in Britain, and with a scope of practice similar to that permitted to chiropodists in Britain.*
- 178** That a course in chiropody be established in Ontario either in a College of Applied Arts and Technology or in some other appropriate educational institution.
- 179** That such a course in chiropody should be not longer than three years, having an entrance requirement initially of grade thirteen with the possibility that, upon review by the Department of Health and the Ontario Council of Health, those with grade twelve might be considered at a later date. The course should be similar to the training programs for British chiropodists.

This training in chiropody is intended only to provide students with an introduction to general surgical principles and to those conditions which may require a surgeon's attention. For this reason the Committee finds it necessary to restrict the practice of surgery.

Recommendation:

- 180** That chiropodists not be permitted to practise surgery, other than minor cutting of the skin which may be required in the treatment of such matters as ingrown toenails.

In view of our conclusion that the training for chiropodists in Ontario should be modelled along that of the British, and as that training introduces students only to elementary pharmacy and includes a study of drugs for external medicine only, the Committee finds that chiropodists need not be given the right to prescribe drugs or to use anaesthetics other than topical at this time. As the training will be subject to change in the future, however, and as pharmaceutical knowledge is changing rapidly, the Committee wishes to see this limitation remain under study in the future by the Department of Health and the Ontario Council of Health with a view towards modification at a later date.

Recommendation:

- 181** That chiropodists not be given the right to prescribe drugs or to use anaesthetics other than topical. However, the Committee urges that this limitation be kept under study by the Department of Health and the Ontario Council of Health to see if it should be modified in the future.

*See minority opinion, pp. 530-531.

The Committee is concerned that those persons who may utilize x-ray equipment be limited. The Committee has been persuaded, however, that x-ray pictures are necessary to the chiroprapist for a proper diagnosis.

Recommendation:

- 182** That chiroprapists should not have the right to use x-ray facilities directly, but should be empowered to refer patients to hospitals or private x-ray facilities in order to obtain necessary x-ray pictures for the diagnosis of foot problems, and that the x-ray pictures should be given to the chiroprapist.

Since some American-trained podiatrists presently practising in Ontario possess skill in x-ray diagnosis and may have a considerable investment in x-ray equipment, a "grandfather clause" should be included in the regulations under the new Act to enable these practitioners to continue to perform their own diagnostic procedures.

Recommendation:

- 183** That there be included in the new legislation governing chiroprody an exemption to permit American-trained chiroprapists presently practising in Ontario to continue to use x-ray diagnostic equipment directly.

The Committee notes the present confusion surrounding the chiroprapist and his relationship to private laboratory facilities. Chiroprapists claim that laboratories sometimes will handle their work and sometimes refuse. Laboratory work is necessary to a chiroprapist so that he may diagnose properly and, therefore, he should have untroubled access to such facilities. Because of the chiroprapist's limited training, however, the Committee desires that a competent person in the laboratory make the interpretation of the tests; if the results indicate a condition beyond the chiroprapist's scope, there should be mandatory referral of the patient to a physician.

Recommendation:

- 184** That chiroprapists have access to public as well as private laboratory facilities for necessary tests on their patients, but that the interpretation of these tests should be done by a competent person operating the laboratory with the interpretation then being given to the chiroprapist, and that if the results indicate a condition beyond the scope of treatment of a chiroprapist, there should be mandatory referral of the patient to an appropriate physician.

On the question of fees, chiroprapists are guided by their professional association which sets a relative value schedule for the various procedures of their practice. It is not mandatory, however, that a chiroprapist adhere to this schedule. The

most recent relative value guide for the profession was published by the Canadian Podiatry Association in July 1968. Its purpose is to show the relationship of one procedure to another, and not to establish set fees. Insurance companies giving coverage for chiropody treatment generally pay for fees equal to those of physicians, making use of the Ontario Medical Association schedule.

Most chiroprapists (83 per cent) practise alone, while 13 per cent practise with either one or two other chiroprapists. Twenty-eight of the practitioners have no clinical assistants, while 57 per cent have one assistant, and 13 per cent have at least two assistants. These assistants work only in the capacity of secretary or receptionist. Chiroprapists conduct most of their practice in their own offices.

The only setting other than their offices in which chiroprapists practise in Ontario is a hospital clinic. The first hospital chiropody clinic in Ontario was established at Riverview Hospital, Windsor, in 1954. Since that time there have been similar clinics established in eight other hospitals in the province. The Ontario Podiatry Association has organized a Hospital Committee to regulate a rotation schedule for each clinic, so that the work is shared among practitioners. The Ontario Hospital Services Commission remunerates chiroprapists in hospitals in Ontario, although not sufficiently to cover the full rate of the chiropody Association fee schedule for the services provided.⁴⁴ The Committee thinks it desirable that the chiroprapist be fully compensated for his services in hospitals. We are of the opinion that services of a given type which are insured if provided by one discipline should also be covered if satisfactorily provided by another discipline.

Recommendation:

185 That chiroprapists' services in hospitals be covered by hospital insurance, and that provision for payment of the salaries of chiroprapists in hospitals as requested be included by the Ontario Hospital Services Commission in the budget of the requesting hospital.

The majority of chiroprapists who make use of hospital facilities treat patients in the outpatient clinics.⁴⁵ There are at least two Ontario chiroprapists, however, who treat inpatients under the supervision of a physician. A physician will arrange for a patient to be hospitalized on the recommendation of one of these particular chiroprapists.

In the United States, the position of chiroprapists in hospitals is set out by the Joint Commission on Accreditation of Hospitals. This Commission provides that:

⁴⁴Communication to the Committee on the Healing Arts, from the Ontario Podiatry Association.

⁴⁵The Board of Regents of Chiropody, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, p. 1339.

The governing body of a hospital, on the recommendation of the Medical Staff, may grant a qualified podiatrist privileges within his area of practice. The Medical Staff must evaluate the qualifications of each podiatrist who applies for hospital privileges. The degree of privileges accorded each podiatrist must be determined by his professional education, training, experience, competence and his demonstrated character and judgement. A podiatrist with hospital privileges may initiate the admission procedure of a patient with the concurrence of a member of the Medical Staff, but no admission is completed without such concurrence. The Medical Staff member concurring in a patient's admission assumes responsibility in the overall care of the patient, including the medical history and physical examination . . .⁴⁶

Those podiatrists practising in American hospitals receive payment in at least one of the following ways: from the patient's insurance carrier; via an exchange system whereby the podiatrist is given permission to use hospital operating facilities for his own patients in turn for taking care of the hospital's patients; or by an honorarium from the hospital to cover some of the costs of charity patients treated by the podiatrist.

Only a few of the chiropodists in Britain are employed by hospital authorities (in 15 per cent of the hospitals in Britain) and only 10 per cent are in full-time employment with the local health authorities.⁴⁷ Chiropodists in Britain do not work under medical supervision, and they are responsible for their own diagnosis, as well as treatments.

Although physicians in Ontario do refer patients to chiropodists, whether or not they may do so within the meaning of the Medical Code of Ethics is not clear. The Committee agrees with the Ontario Podiatry Association's submission that chiropody should be recognized by the Ontario Medical Association, in that physicians may ethically refer patients, work with chiropodists in accredited hospitals, and teach in schools of chiropody. The Committee has received no evidence which would indicate that chiropodists do not refer to physicians those cases which fall beyond their scope of practice. However, the Committee wishes to ensure that chiropodists have sufficient training so that they may be able to diagnose those conditions which should be referred to a physician.

Recommendation:

- 186** That chiropodists should be regarded as independent practitioners entitled to carry on private practice without referral from physicians and that their training enable them to know when to make referrals to physicians.

In its brief to the Committee the Board of Regents of Chiropody noted that a chiropodist had participated in a clinical orthopaedic course for general practitioners

⁴⁶*Report of the Joint Commission on Accreditation of Hospitals*, March 1967; submitted with Supplementary Brief of the Board of Regents of Chiropody, 1967, pp. 1-6.

⁴⁷Communication to the Committee on the Healing Arts, Society of Chiropodists, May 27, 1968.

sponsored by the University of Toronto, Faculty of Medicine in 1962.⁴⁸ The Board recommended that there should be more such joint medical-podiatric continuing education seminars. The Committee regards this kind of interdisciplinary cooperation as desirable. In general, we believe that many of the existing barriers between the various health care disciplines should be abolished. The teaching of students in one discipline by practitioners in other related disciplines is desirable in that it may help to break down isolation and misunderstanding between groups, and in that such interaction is in the best interests of patients.

Recommendation:

- 187** That physicians should be encouraged to teach in schools of chiroprody, and that any existing barriers to teaching by physicians be removed.

In this field, as in others, controversy continuously surrounds the use of the title "Doctor" (this subject is dealt with more extensively in Chapter 25). The Committee is concerned that the public may be misled as to the qualifications and identity of the practitioner they choose. Accordingly, as has been recommended in relation to other disciplines, we wish to ensure the continuation of restrictions on the use of the title "Doctor".

Recommendation:

- 188** That chiroprodists continue to be prohibited by law from using the title "Doctor", with or without a qualification.

Chiroprody is not presently included under the Ontario Health Services Insurance Plan. However, many other insurance plans cover the type of practitioner who renders the service and not the condition. Some insurance carriers will pay for chiroprody services provided the patient has a medical referral. Since 1968 chiroprody services have been covered by medicare in the United States with no limitations on the number or nature of treatments, except that the chiroprodist must practise within the legal limitations of the state in which he is practising.

It is clear that chiroprodists perform some procedures which would be covered by insurance if performed by a physician or by another type of practitioner under his direction in a hospital. We believe that in order to avoid distortion in personal health care treatment and to make efficient use of personnel it should be the service which is insured, not the discipline.

Recommendation:

- 189** That in the treatment of foot conditions within the scope of practice of a chiroprodist and covered under the Ontario Health Services Insurance Plan, patients should have free choice of the services of a physician or a chiroprodist.

⁴⁸The Board of Regents of Chiroprody, Brief to the Committee on the Healing Arts, 1967, p. 7.

Regulation

The practice of chiropody in Ontario is regulated by the Chiropody Act.⁴⁹ This Act established the Board of Regents, which has five members appointed by the Lieutenant Governor in Council for a period of two years and eligible for reappointment. The Board consists of a chairman, a vice-chairman, secretary-treasurer, and two members. Although not required by the Act, all members of the Board are chiropodists registered under the Act.

The Board is responsible for administering the Chiropody Act and the regulations made under the Act. Its major functions include specifying requirements for registering practitioners; specifying guidelines for appropriate behaviour and disciplining practitioners for misconduct; and prescribing qualifications or standards for the training of chiropodists and approving professional schools.

The Act does not require any standing committees within the Board, but committees may be appointed to consider any particular matter. The Board appoints examiners to conduct examinations of applicants for a licence, retains legal and auditing services, and employs investigators. All administrative work of the Board is either conducted on a voluntary basis by the members themselves, or is paid for on an honorarium basis. The Board derives its income entirely from examination fees, which are \$100 per applicant, and its annual registration fee of sixty dollars. The Board's total income in 1965 was \$4,140, of which close to one-half (\$1,875) was used to pay solicitors' fees.

The qualifications for registration as a chiropodist in Ontario are stated in the regulations under the Chiropody Act. They include that an applicant must be at least twenty-one years of age, of good moral character, and a graduate of an approved chiropody college, and that he must have completed at least three months of a clinical internship under the supervision of a registered chiropodist. In addition to paying a registration fee, an applicant must also pass an examination which covers the following subjects: anatomy and histology, bacteriology, chemistry, materia medica and therapeutics, clinical chiropody and technique, dermatology and syphilology, hygiene and sanitation, pathology, physiology, and x-ray and diagnosis. To be allowed to write the examinations, the candidate must have grade thirteen standing in nine papers, including physics, chemistry, botany and zoology, or an equivalent standing.

Persons may be registered without examination if they are registered as a chiropodist in a jurisdiction outside Ontario which has regulations similar to those provided by the Act.

Examinations are conducted at least once a year by two chiropodists, one of whom is a member of the Board. The Board first approves the examination questions, and later reviews and approves the marks given by the examiners.

⁴⁹R.S.O. 1960, c. 54.

The Board of Regents is responsible for the discipline of chiropodists. There is no routine inspection of chiropodists' practices, and an investigator is hired only for the investigation of written complaints. The Board considers a routine inspection to be unnecessary and expensive.

Since 1944 the Board has had only two or three disciplinary hearings. It appears that it is most reluctant to discipline members of the profession. In the past, the Board has not prosecuted chiropodists who use the prefix "Doctor", for it considers that chiropodists should have this right. A routine notice is sent by the Board to a chiropodist who is found to use "Doctor" on his stationery. According to the existing legislation, chiropodists are not permitted to be employed by commercial businesses, and two discipline cases are recorded in conjunction with violations of this rule. The Board turns over complaints regarding chiropodists charging exorbitant fees to the Ethics Committee of the Ontario Podiatry Association.

Persons who are not registered under the Act but do practise as chiropodists can be prosecuted under section 5 of the Chiropody Act. In the past the Board has had four or five complaints involving pedicurists.

The Board has never taken disciplinary proceedings against a chiropodist on the grounds that he has exceeded the scope of practice permitted by the legislation. The Board has indicated that it would not initiate disciplinary proceedings in such a situation, provided that the treatment fell within what the Board considers are the rights of chiropodists,⁵⁰ and the Board has placed a very broad interpretation on the definition of "chiropody" in section 4 of the Act. As stated in the regulations, the Board, after the hearing, may suspend or cancel registration. The period of suspension shall not be longer than thirty days.

It is consistent with our proposals regarding the establishment in Ontario of the practice of chiropody modelled along British lines that British-trained chiropodists be able to practise here. This would provide an immediate supply of additional foot care personnel for Ontario.

Recommendation:

190 That chiropodists, educated at an approved school of chiropody in Britain or elsewhere in schools providing training equivalent to the training recommended in Recommendation 179, should be entitled to practise in Ontario.

Although we have stated that the chiropodist's present scope of practice should not be extended beyond that defined in the present Chiropody Act, we do propose that chiropodists should continue to be permitted to deal with the public directly without medical referral. Thus it is desirable that they should be licensed. The

⁵⁰The Board of Regents of Chiropody, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, pp. 1342-1344.

Committee believes, however, that a proliferation of independent regulatory bodies is undesirable and that a Health Disciplines Regulation Board should be established (see Chapter 25) to regulate most of the healing disciplines in Ontario, other than the disciplines specifically exempted from this provision. It is envisaged that there will be a division of the Board for each discipline, the membership of which will contain a slight majority of appointed practitioners from each relevant discipline, to advise the Board on matters of licensing, certification and regulation. Accordingly we propose that the licensing of chiropodists, including the existing numbers of podiatrists, should be administered by the proposed Health Disciplines Regulation Board through an appropriate Division for chiropody.

Recommendation:

191 That chiropodists be licensed by the Health Disciplines Regulation Board through a Division for chiropodists.

Voluntary Association

The Ontario Podiatry Association was formed in 1925 and incorporated in 1943. Prior to 1964, when its present name was adopted, the Association was called the Ontario Association of Chiropodists. Approximately 70 per cent of chiropodists practising in Ontario are Association members. Membership is voluntary and is open to those persons who are licensed to practise chiropody in Ontario and who agree to adhere to the Association's By-Laws and Code of Ethics. Membership fees are \$100 per year, of which thirty dollars are turned over to the Canadian Podiatry Association to cover its membership dues.

The objectives of the Association are to bring chiropodists in Ontario together for their betterment; to elevate the standards of education of chiropodists; to endeavour to secure the enactment of just laws with respect to chiropody; to promote friendly intercourse amongst chiropodists; to guard, foster, and protect the rights and interests of members of the Association; and to enlighten and direct public opinion concerning matters pertaining to chiropody and chiropodists.

The administrative structure of the Association consists of a Board of Directors, an Executive Committee, and various other committees, such as the Insurance Committee, Student Liaison Committee and Hospital Clinics Committee. There are eleven Board members who are elected for a one-year term at the annual meeting of the Association.

Although not explicitly stated as one of its formal objectives, the Association considers one of its important tasks to be that of defining ethical standards for practitioners, and has drawn up a Code of Ethics for chiropodists. The only action that the Association may take to discipline a practitioner for misconduct is to deprive him of membership in the organization.

That Association is responsible for setting the fee schedule to guide chiropodists. Consistent with our recommendations on remuneration of other disciplines, in which we determined that fee schedules covered by publicly financed insurance should not be unilaterally established by the practitioners' associations, we believe that chiropodists' fees should be subject to negotiation.

Recommendation:

- 192** That the fee schedule published by the Ontario Podiatry Association be a matter of prior negotiation by the Association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.⁵¹

⁵¹See Chapter 24.

Chapter 16 Health Therapists

This chapter is concerned with personnel who provide various kinds of therapy to persons suffering from some disability, as a result of either illness or accident, or from a congenital malady. The groups to be considered are physiotherapists, occupational therapists, remedial gymnasts, masseurs, speech therapists, clinical audiologists and hearing aid dispensers.

The study of paramedical occupations undertaken by Oswald Hall for this Committee¹ provides much of the basis of the discussion in this chapter on physiotherapists, occupational therapists and speech therapists. Information on hearing services was included in an unpublished study for the Committee² and internal research papers were prepared on remedial gymnasts and masseurs.

TABLE 16.1
Number of Various Health Therapists in Ontario, 1968

Physiotherapists	1,106
Occupational therapists	299
Masseurs	386
Remedial gymnasts	36 (1967)
Speech pathologists and audiologists	74
Hearing aid dispensers	167 (1969)

SOURCE: See Table 6.3, Chapter 6.

The numbers in each of these groups in Ontario are given in Table 16.1. The main function of each may be stated as follows:

- 1) Physiotherapists are concerned with “movement”, with the exercise, patterning, and restoration of functions of muscles and limbs of patients, on an individual basis, employing techniques such as exercise, hydrotherapy, electrotherapy.

¹Oswald Hall, *The Paramedical Occupations in Ontario*, Committee on the Healing Arts, Queen’s Printer, Toronto, 1970, Ch. 10.
²*Pharmacy, Vision and Hearing Services*, an unpublished study for the Committee on the Healing Arts, 1967.

- 2) Occupational therapists treat patients through the teaching of normal activities such as work, manual skills, recreation, interpersonal relationships, activities of daily living, to restore physical and mental functions, maintain or improve existing health functions.
- 3) Remedial gymnasts aid in the restoration of sick and disabled persons both through the scientific application of body movements, usually to a group in a gymnasium setting, and through therapeutic recreational activities in which competitive or team games are used to create or redevelop maximum mental and physical functions.
- 4) Masseurs knead, rub and massage the body without adjusting any of the boney structure, and may also use steam, electric light, vapour or fume baths, thermal or ultraviolet lamps in their treatments. Massage may be considered medical in nature when applied as a treatment for an ailment.
- 5) Speech therapists treat, through specialized speech training adapted to the needs of the patient, persons suffering from speech problems in the use either of language or of the voice which may result from physical or emotional disturbances.
- 6) Audiologists determine the range, nature and degree of a patient's hearing function through the use of specialized electroacoustic instruments, and after coordinating these results with other diagnostic data, recommend the type of assistance which a patient may need to alleviate a hearing problem.
- 7) Hearing aid dispensers are commercial vendors of hearing aids, who advise a customer on the appropriate aid and fit the aid for the customer.

Rehabilitative services have never occupied the same focal role in health care as services related to care and cure. However, there is today much greater recognition of the need to return a patient to the community in full health than there was in 1918 when Mr. Justice Hodgins devoted a major part of his Report to the need for greater emphasis on physical therapy services.³ Even so, there has been little study of the roles, manpower needs, and educational requirements for personnel in rehabilitation, and much needs to be done in planning and organizing the necessary resources for this field. Apart from all other considerations, the cost to the community of the loss of the services of a person cured but not yet rehabilitated is the same as the cost in the case of the person not yet cured. From this point of view rehabilitation is as urgent a matter as cure.

In this chapter we look at each of these disciplines and recommend the changes which we believe are necessary. But the major change is an increase in attention, so largely focused now on diagnosis and cure, to produce more adequate resources and higher standards of rehabilitation.

³*Report on Medical Education in Ontario, 1917* (The Honourable Mr. Justice Hodgins, Commissioner), King's Printer, 1918.

Physiotherapists

History

Physiotherapy as a recognized discipline had its origins in the early part of the twentieth century when, with the impetus of World War I, the importance of physical therapy was recognized in rehabilitation of wounded soldiers. The Canadian Physiotherapy Association was incorporated in 1920 and the first university school of physiotherapy in Canada was established when, in 1929, the University of Toronto commenced a two-year diploma program. This was the only program in Canada until 1943 when McGill University initiated its physiotherapy course.

From 1925 until 1935 physiotherapists and masseurs were included in the same classification under the Drugless Practitioners Act which had been enacted in 1925. A Board of Regents, appointed under the Act, was responsible for the regulation and discipline of all groups of drugless practitioners.

In 1935 a separate classification for physiotherapists was established under the Drugless Practitioners Act. The Board of Regents continued as the regulatory body, and physiotherapists had one representative on the Board.

During the 1940's physiotherapists employed in hospitals were not required to register with the Board. However, in 1954, a year after separate Boards of Directors were established under the Drugless Practitioners Act, to regulate each of the classifications of health practitioners covered by the Act, the Board of Directors of Physiotherapy passed a regulation requiring that all physiotherapists register before being entitled to practise as qualified physiotherapists in Ontario. The number of physiotherapists registered in Ontario has increased from eighty-two in 1930⁴ to 1,259 in February 1969.⁵

The educational program for physiotherapists at the University of Toronto was expanded from two years to three years in 1946 and was combined with occupational therapy in 1950 under the Division of Rehabilitative Medicine within the Faculty of Medicine. In order to qualify for membership in both the Canadian Physiotherapy Association and the Canadian Association of Occupational Therapists, graduates of this program must take a four-month approved internship in physiotherapy and four months in occupational therapy. This internship also satisfies the clinical experience requirement for registration with the Board of Directors of Physiotherapy.

Role

In his study for the Committee Hall found it difficult to develop a complete or concise job description for physiotherapists. The physiotherapist, he noted, treats a physical problem in a physical sense, rather than surgically or chemically, and

⁴Board of Directors of Physiotherapy, reply to Questionnaire "A", Committee on the Healing Arts.

⁵Official Register of the Board of Directors of Physiotherapy, March 1, 1968 to February 28, 1969.

uses a variety of techniques—for example, exercises, hydrotherapy and electrotherapy. “Basically the therapist deals with ‘movement’, with the exercise, patterning and restoration of functions of muscles and limbs of patients on the mend after an accident or operation.”⁶

In the regulations governing physiotherapists under the Drugless Practitioners Act the system of treatment that may be followed by physiotherapists is the treatment of persons by

- c) the massaging and manipulating of the body;
- d) the use of (i) radiant and electrical energy, except radiant energy from radio-active materials or x-ray machines, and (ii) mechanical energy; and,
- e) the exercising of a body in any suitable medium.⁷

In a draft Act to regulate physiotherapy submitted to the Committee, the Board of Directors of Physiotherapists suggested that existing legislation did not adequately define physiotherapy or the role of the physiotherapist, and that in new legislation to govern physiotherapists, physiotherapy should be defined as follows:

- e) Physiotherapy means physical therapy and includes the science and art of treating and training sick and disabled persons in order to enable them to regain the maximum function of which they are capable by use in any suitable medium of: (i) remedial exercises, massage and manipulation; (ii) radiant, mechanical or electrical energy; (iii) hydrotherapy.⁸

Physiotherapists, excepting those registered under the Drugless Practitioners Act prior to January 31, 1955, are at present restricted to treating “upon a prescription”. Prescription, however, is not defined and the Board of Directors of Physiotherapy have recommended that such a definition be included in any new legislation. The following definition has been suggested:

Prescription means a direction of a duly qualified medical practitioner directing a physiotherapist to treat a named person.⁹

In practice, especially within a hospital, the prescription may take the form of a requisition signed by the physician or in some cases by the physiotherapist or nurse upon a notation by a physician on the patient’s chart for routine physiotherapy. With outpatients, physicians often phone in prescriptions, and this is sometimes the practice in hospitals as well.¹⁰

The Committee suggests that in the new legislation which would be required to implement the recommendations regarding regulation of physiotherapists (see pp. 372 ff.), such definitions or definitions similar to them in intent be included.

The majority of employed physiotherapists work in hospitals. Some may also be found in chronic care institutions, nursing homes and special rehabilitation

⁶Oswald Hall, *op. cit.*, p. 104.

⁷R.R.O. 1960, Reg. 120, s. 3 (3).

⁸“An Act Respecting the Practice of Physiotherapy”, submitted by the Board of Directors of Physiotherapy to the Committee on the Healing Arts, Section 2 (c).

⁹*Ibid.*, Section 2 (f).

¹⁰Oswald Hall, *op. cit.*, p. 109.

centres such as the Workmen's Compensation Board Hospital, and in private agencies such as the Canadian Arthritis and Rheumatism Society and the Ontario Crippled Children's Centres. More recently physiotherapists have also been employed by agencies in municipalities operating home care programs to carry out necessary physiotherapy treatments in a patient's home. These services are eligible for payment by the Ontario Hospital Services Commission.

Physiotherapists generally work in a fairly unstructured setting with little supervision. However, in hospitals the competence of the physiotherapist may be assessed by the head physiotherapist or by the physician who orders the treatment.

The functions of the physiotherapist are not strictly demarcated. In some instances nurses or other aides may carry out "physio-activity" which is closely allied to physiotherapy. Some of the physiotherapist's time may also be spent on activities which do not fully utilize her skills and which could be carried out by lesser trained persons.

In our opinion this is an area which requires further study. It is quite possible that university-trained physiotherapists might be better utilized in supervision, administration and teaching, and that some of the more routine physiotherapy tasks could be allocated to physiotherapy technicians possibly trained in shorter programs at Colleges of Applied Arts and Technology. Such a development would be in keeping with the recommendations made by the President's Research Committee to the Committee of Presidents of Universities of Ontario.¹¹

The Committee believes that controlled experiments in the varying utilization of physiotherapists and aides should be undertaken, as well as studies of information already gathered elsewhere, in order to develop the most effective combination of rehabilitative personnel.

Recommendation:

- 193** That the Ontario Council of Health and the Department of Health examine experience elsewhere and undertake controlled experiments to study how alterations in the role and function of physiotherapists and physiotherapy technicians might prove beneficial to hospitals or other employing agencies as well as to the employees themselves.

Manpower

As of February 1969 there were 1,259 registered physiotherapists in Ontario.¹² Of these, only 149 were males; 1,164 were in active practice in Ontario.

The number of registered physiotherapists in Ontario increased markedly during the 1960's and has almost tripled since 1958. The physiotherapist:population ratio has also improved notably from 1:13,320 in 1958 to 1:5,871 in 1969.¹³

¹¹Committee of Presidents of Universities of Ontario, *The Health Sciences in Ontario Universities*, University of Toronto Press, Toronto, 1966, p. 4.

¹²Official Register, Board of Directors of Physiotherapy, Province of Ontario, March 1, 1968 to February 28, 1969.

¹³Table 6.45, Chapter 6.

This change has resulted primarily from the increased numbers of foreign-trained physiotherapists who have immigrated to Ontario. In 1968 of the 259 new registrants (not including re-registrants), 166 were educated outside Ontario. The greatest influx of physiotherapists has been from the United Kingdom, with seventy-four coming in 1968. In the same year twenty-two Australian-trained physiotherapists were newly registered in Ontario.¹⁴

It would be unwise, however, for Ontario to continue to rely so heavily upon physiotherapists trained outside Ontario to meet its manpower requirements. There is no assurance that such an influx will continue indefinitely, and it is necessary to ensure that adequate numbers are being trained within the province to meet future demands.

There is also a high turnover of physiotherapists in practice with estimates of the attrition rate running as high as 75 per cent by the end of the third year after graduation.¹⁵ More recent figures indicate that only 75 per cent of physiotherapists are still working one year after registration, with the percentage decreasing to 39.5 per cent six years after registration.¹⁶

In 1969, there were 1,034 physiotherapists employed on a full-time or part-time basis in hospitals or clinics. Of these, fifty-nine also had a part-time private practice, while another 130 were also engaged in either full-time or part-time private practice.¹⁷

The development of the private practice of physiotherapy became more attractive when, in September 1964, the Ontario Hospital Services Commission (OHSC) began to cover private outpatient physiotherapy when prescribed by a physician, and where it was not possible for the treatment to take place in a hospital setting. Approximately 200 physiotherapists have been approved under the plan, about half for private office practices and the other half for providing visiting services to patients' homes. However, because more recently there have been significant increases in the numbers of physiotherapists employed both for inpatient and outpatient services through hospitals, the need for additional physiotherapists in private practice to meet the demands for physiotherapy treatment prescribed by physicians has diminished. Therefore additional physiotherapists in private practice will be eligible for inclusion in the plan only in areas where there may not be adequate physiotherapy services available through a local hospital.

We believe, however, that physiotherapy is a vital part of health services and that there should be no financial impediment to the patient requiring such services wherever they may be provided. The Committee also believes that physiotherapy

¹⁴Official Register, Board of Directors of Physiotherapy, Province of Ontario, March 1, 1968 to February 28, 1969.

¹⁵The Continuing Committee of the Canadian Conference on Physiotherapy. Submission to the Royal Commission on Health Services, April 1962, p. 11.

¹⁶R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Table A168.

¹⁷Information received directly from the Board of Directors of Physiotherapy.

should not necessarily be considered only as part of hospital services, but should be included among general health services with insurance coverage more logically included under OHSIP rather than OHSC. If such a transfer were made, the services of a registered physiotherapist should be covered, wherever provided. We recognize, however, that extending such coverage may make the private practice of physiotherapy even more attractive than it is at present, and that there could be an outflow of physiotherapists from hospital employment to private practice. The remedy to this situation would be to increase the attractiveness of institutional employment by improving salaries and working conditions in such employment.

Recommendation:

- 194** That the services of licensed physiotherapists in private practice be covered under publicly financed health insurance plans wherever the treatments are provided.

With the implementation of the above recommendation, the employment of physiotherapists in group medical practices also would become more attractive, as would the inclusion of physiotherapy services in home care programs. However, if physiotherapist fees are to be covered by publicly financed health insurance such fees must, as in the cases of other practitioners, be a matter of prior negotiation between the physiotherapists' voluntary association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee (see Chapter 24).

Recommendation:

- 195** That the fee schedule for physiotherapists be a matter of prior negotiation by the physiotherapists and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.

Education

The first university program in physiotherapy in Ontario was established at the University of Toronto in 1929, and this was the only course available until 1966 when the University of Western Ontario established a four-year degree program. Queen's commenced a three-year diploma course in 1967.

The program at the University of Toronto is combined with occupational therapy and can accept 110 first-year students each year. In 1968 the school received 250 applications from qualified applicants with a grade thirteen average of over 65 per cent.

The four-year degree program at the University of Western Ontario is offered by the Department of Physical Medicine and Rehabilitation of the Faculty of Medicine and leads to a Bachelor of Science and Medical Rehabilitation (Physical Therapy) degree (B.Sc.M.R.). The first year is spent in a general program in the Natural Sciences in the Faculty of Arts and Science and the three subsequent years in a professional program of physiotherapy. As with graduates of other schools, the students are required to take the four-month internship period at an

approved hospital to fulfil the eligibility requirements for membership in the Canadian Physiotherapy Association and for registration. Part of this may be undertaken in the summer preceding the final academic year.

The diploma program for physiotherapists at Queen's University will have its first graduates in the spring of 1970. The students take twelve weeks of supervised clinical practice between the second and third year. While the physiotherapy program is separate from occupational therapy at Queen's many of the subjects are common to both and are taken together. Eventually the university plans to add a fourth year, which would lead to a Bachelor of Science degree and which also would be open to graduates of the diploma program upon completion of two years of clinical practice. Ultimately the school anticipates that the diploma program will be completely replaced by a continuous four-year degree program.¹⁸

Mohawk College of Applied Arts and Technology in Hamilton plans to commence a thirty-three month (three years of eleven months each) program in physiotherapy in September 1970, in conjunction with the Hamilton Health Association and McMaster University. This program will require only grade twelve as a prerequisite. Mohawk College will be responsible for the basic subjects of the first year and for the physiotherapy subjects throughout the program. The Hamilton Health Association clinical facilities will be used during the second and third years, as will facilities of local hospitals. McMaster University has agreed to provide instructors for courses such as anatomy and physiology.

Graduating students will receive a diploma from Mohawk College and a certificate from the Faculty of Medicine of McMaster University. It is also possible that McMaster University will develop a program by which graduates of the Mohawk College program may obtain a degree upon completing further training at the university.

One of the most contentious issues within the profession is the location and length of education programs for physiotherapists. On the one hand, spokesmen for the Ontario Branch of the Canadian Physiotherapy Association maintain that all educational programs must be located in or affiliated with a university.¹⁹ They also believe that degree programs should be available and that there is a need for greater upward mobility within the profession in order to allow present diplomates to proceed towards degrees, and then on to postgraduate study.

The President's Research Committee of the Committee of Presidents of Universities of Ontario, on the other hand, in its report, *The Health Sciences in Ontario Universities*, in its discussion of physiotherapists stated:

. . . the large numbers of health personnel required should be trained in hospital schools or technical colleges in shorter programs with less stringent

¹⁸Information received by the Committee on the Healing Arts in a letter from a senior teacher of physiotherapy at Queen's University.

¹⁹Ontario Branch, Canadian Physiotherapy Association, Brief to the Committee on the Healing Arts, 1966, p. 8.

requirements, while at the same time providing a means for such graduates to enter university degree programs possible with advanced standing for specially qualified graduates of the diploma schools. The universities would then be free to prepare individuals to take leadership and responsibility in clinical care, in the development of graduate programs and professional education, administration, research and clinical specialties.²⁰

This report also indicated that smaller schools of physiotherapy might be established in relation to each of the Ontario medical schools which could over the next ten years produce in total 250 therapists per year—155 being physiotherapists.²¹ Additional physiotherapists could then be provided through shorter diploma courses established in Colleges of Applied Arts and Technology.

At present rates of growth, the existing three university programs could, within the next five years, be producing approximately 140 graduates a year. Only a slight expansion of the present schools or one additional school would be needed to meet the requirements for graduates foreseen by the President's Research Committee.

We agree that university programs in physiotherapy should be degree rather than diploma programs. We believe that physiotherapy is an appropriate discipline to be taught within a university, and that it should be accorded degree status. Only in such a way will it also be possible to develop the postgraduate programs which are necessary for the preparation of teachers and senior administrators. At the same time every attempt should be made not to extend education programs unnecessarily, and we hope that those responsible for the development of degree programs in physiotherapy will seek ways to offer the program in the most efficient way possible. Efforts could be made to provide the necessary clinical experience during the program to eliminate the need for a further internship period. We are not at this time recommending the development of a second level of physiotherapist trained at a College of Applied Arts and Technology, requiring only grade twelve as an educational prerequisite, with the length of the program being two to three years. We believe, however, that there could be significant benefits derived from the introduction of such courses which could produce the increased numbers required in this field, in a shorter period and at least at less cost. This should be a matter for immediate further study by the Department of Health and the Ontario Council of Health. If such courses are introduced, an appropriate Educational Advisory Committee should be appointed.

Recommendations:

- 196** That the present educational programs for physiotherapists located in universities should continue but that such programs should take place, where possible, within schools of health sciences.

²⁰Committee of Presidents of Universities of Ontario, *op. cit.*, p. 4.

²¹*Ibid.*, p. 13.

- 197** That if studies recommended regarding the role of physiotherapy personnel reveal there is a need for a second level physiotherapist, such personnel should be educated in programs at the Colleges of Applied Arts and Technology.
- 198** That educational programs for physiotherapists at universities presently offering diploma programs be upgraded to degree courses as soon as feasible.

Another principle which the Committee has adopted in its considerations of the health disciplines is the necessity of allowing health workers to have access to advanced academic work, and we will feel this should certainly apply to physiotherapists. The program at Queen's University which enables graduates of diploma programs to continue towards a degree by returning for a further year's education is a desirable arrangement. The Committee believes that any graduates of diploma programs should be able to take advantage of this opportunity and that two years' practical experience should not be required for entry to these programs.

Recommendation:

- 199** That graduates from diploma courses in physiotherapy be able to continue into degree programs with appropriate credits being given for their diploma courses.

Accreditation

At the present time the only accreditation of educational programs of physiotherapy is carried out by a joint committee of the Canadian Physiotherapy Association and the Canadian Medical Association. While we have recommended in other areas that accreditation of education programs be transferred from voluntary organizations to new agencies, there does not appear to be another suitable agency which could be responsible for such accreditation at this time. Therefore, the Committee recommends that the present accreditation program be continued. Only if such a program were not responsive to Ontario needs should the Province establish provincial accreditation arrangements.

Recommendation:

- 200** That accreditation of schools of physiotherapy in Ontario should continue to be under the auspices of the Canadian Physiotherapy Association and the Canadian Medical Association.

At present the physiotherapist must complete a four-month internship approved by the Canadian Physiotherapy Association before being eligible for membership in the professional association. The four-month internship in physiotherapy also fulfils the clinical experience requirements outlined in the Regulations of the Board of Directors of Physiotherapy, on completion of which the physiotherapist is eligible for registration with the Board. The accreditation of hospitals to provide these internships also is done jointly by the Canadian Physiotherapy Association and the Canadian Medical Association.

In general the Committee has expressed its opinion that internship programs should be under the control of the educational institution. However, in this case the requirement is national, being that of the Canadian Physiotherapy Association, and if Ontario physiotherapists did not meet this requirement they could encounter difficulty in registering in other provinces and therefore find their mobility limited.

The Committee believes that wherever possible national standards and inter-provincial mobility should be encouraged for health personnel. At present, therefore, the Committee does not recommend that the internship program be eliminated or rearranged. However, we suggest that the Ontario section of the Canadian Physiotherapy Association work in cooperation with other provincial sections of the Canadian Physiotherapy Association towards the incorporation of this internship period within the formal educational program and its supervision by the educational institutions.

Recommendation:

201 That the internship period required by the Canadian Physiotherapy Association for membership in that Association and for registration as a physiotherapist in Ontario should continue for the present, with internship programs being accredited jointly by the Canadian Physiotherapy Association and the Canadian Medical Association.

Postgraduate Education

The only postgraduate program for physiotherapists is offered at the University of Toronto. This is a diploma course of two years' duration which prepares physiotherapists to become teachers of physiotherapy. Entrance requirements for this program include a diploma in physiotherapy and three years' practical experience. In 1967-1968 there were only six persons enrolled in this course. It has not played a major role in providing teachers for physiotherapy programs. As the basic University of Toronto physiotherapy program does not have degree status, no postgraduate degree programs can be offered.

The Ontario Branch of the Canadian Physiotherapy Association indicated to the Committee that there is a shortage of teachers of physiotherapy and that in particular the University of Toronto is understaffed by one-third and has had to limit the number of students admitted to the above postgraduate diploma program.²² They recommended that efforts be made to recruit and train sufficient teachers to staff all schools in Ontario and that bursary assistance be established for this purpose.

As an undergraduate degree program is now available in at least one university and as the Committee has recommended that further degree courses be developed, we also believe that a postgraduate degree program should be commenced without

²²Ontario Branch, Canadian Physiotherapy Association, Brief to the Committee on the Healing Arts, 1966, p. 5.

delay, particularly designed to provide necessary teaching personnel. The students in such graduate programs should be eligible for the same financial assistance as other postgraduate students.

Recommendation:

- 202** That a Master's degree program for physiotherapists be established in at least one Ontario university as soon as possible to develop the necessary teaching and research personnel required in physiotherapy.

Continuing Education

There is no formal or compulsory continuing education program for physiotherapists in Ontario. However, occasional continuing education programs are offered either by the voluntary associations or by universities. In addition the Ontario Society of Physiotherapy sponsors an annual two-day postgraduate seminar for its members. Continuation of membership in that society is dependent upon proof of attendance at one seminar or postgraduate course in each two years of practice.

The Ontario Branch of the Canadian Physiotherapy Association also sponsors courses, some in conjunction with the Ontario Hospital Association or other interested groups. An example is a special three-month course conducted in September 1966 in conjunction with the Multiple Sclerosis Society of Canada (Ontario Division) and the Wellesley Hospital in Neuro-muscular Facilitation Techniques. The Rheumatic Diseases Unit at Queen's University has sponsored refresher courses for physiotherapists and occupational therapists on the topic of "Current Concepts in the Management of Patients with Arthritis and Allied Problems".

The Committee supports the development of such courses, but believes that they should be on a continuing basis and that measures should be taken to ensure the continuing competence of physiotherapists as for other health disciplines. This is particularly important for those in private practice where there is less opportunity for continuous review of their work by supervisory personnel. As outlined in the recommendations on continuing education in Chapters 25 and 26 the Committee believes that such programs should be under the jurisdiction of the appropriate institutions.

Recommendations:

- 203** That a program for ensuring continuing competence be implemented for physiotherapists and that periodically, perhaps every five years, every physiotherapist in Ontario be required to present to the Health Disciplines Regulation Board a certificate from an accredited school of physiotherapy in Ontario stating that she has maintained a satisfactory level of competence in the practice of physiotherapy.
- 204** That the accredited schools of physiotherapy in Ontario develop the standards and programs which would be required for such certification.

Refresher Courses

The consequence of the high proportion of females in the field of physiotherapy is that there is also a high turnover rate, as many of the female physiotherapists leave the profession at least for a period of time when they are raising families. However, an increasingly large number of married women return to employment after their children reach school age. It may be expected that many physiotherapists will wish to re-enter their profession and that appropriate opportunities should be made available to them.

Particularly important for such women are the availability of refresher courses to update their knowledge of physiotherapy techniques and practices. The Board of Directors of Physiotherapy at present advises physiotherapists who have not been in active practice for five years or more to undertake some refresher education. Usually this involves working for a limited period of time under the close supervision of a physiotherapist approved by the Board. However, the introduction of general refresher programs particularly in larger urban centres also should be attempted. The Committee believes that, as in the case of nursing, which has been experimenting successfully with the development of refresher courses, much can be done to mobilize this potential source of physiotherapy manpower. The universities and educational institutions should make an early start to undertake such programs.

Recommendation:

205 That refresher programs for physiotherapists should be established in order to attract into employment some of the qualified physiotherapists not now in practice.

At the same time, the Committee hopes that the employers will make opportunities available which will be attractive to physiotherapists not now in practice, including the development of part-time employment opportunities where possible.

Regulation

Physiotherapists in Ontario are presently regulated by the Board of Directors of Physiotherapy, a Board set up by the Lieutenant Governor in Council under the Drugless Practitioners Act. The Board of Directors of Physiotherapy is composed of five members: a chairman, vice-chairman, secretary-treasurer, and two members; all members are appointed by the Lieutenant Governor in Council for periods of two years. Traditionally, recommendations for appointment are received from the two voluntary associations; three are usually appointed upon recommendation of the Canadian Association of Physiotherapy, and two upon recommendation from the Ontario Society of Physiotherapy.²³ This has resulted in the appointment to the Board of Directors of a number of persons who are members of the executives of the voluntary associations. The powers of the Board include admitting

²³Board of Directors of Physiotherapy, reply to Questionnaire "A", Committee on the Healing Arts.

persons to the practice of physiotherapy, maintaining a Register of all persons so admitted, disciplining registrants and prescribing the conditions under which physiotherapists practise their profession.²⁴ Every person who holds himself out as qualified to practise as a physiotherapist in Ontario must be registered by the Board. Those registered may use the designation "Reg. Pht."

The educational requirements outlined in the regulations do not include any specific schools from which the applicant must have graduated. Instead they indicate that registration will be granted to persons who hold a degree or diploma in physiotherapy from any university in Canada which meets the educational requirements outlined in the regulations, or from the Chartered Society of Physiotherapy of the United Kingdom. Graduates from Canadian universities are required to have 1,000 hours of clinical experience under the supervision of a physiotherapist in a public hospital approved under the Public Hospitals Act. While nowhere in the regulations is it provided that membership in the Canadian Physiotherapy Association is required for graduates of Canadian universities, in effect, it appears that all graduates must meet the Association's requirements for membership before being eligible for registration by the Board, including the approved internship of four months.

Physiotherapists trained outside Ontario, apart from those who are members of the Chartered Society of Physiotherapy of the United Kingdom, may gain registration in one of two ways. Those who are members of the Australian Physiotherapy Association, New Zealand Society of Physiotherapists or South African Society of Physiotherapy must first become members of the Canadian Physiotherapy Association and are then eligible for registration. All others must take the examinations established by the Board as prescribed in the regulations.²⁵

In order to be eligible to write the examinations the applicant must have graduated from a school which meets the requirements outlined in section 26 of the regulations, which stipulates the required number of hours and subjects of study. The Board assesses the applicant's education by reviewing the calendar for the school and may refer to the Canadian Physiotherapy Association for a further opinion. The Canadian Physiotherapy Association sets and conducts the registration examinations on behalf of the Board.

The Board is also responsible for discipline of registrants. The Board has the power, after a hearing held in accordance with the regulations, to suspend or cancel registration of any person found guilty of misconduct or found to have been incompetent. No appeal procedure is established. The Board has never had such a hearing or disciplined any member. Since the majority of physiotherapists are employees, any offensive conduct is usually disciplined by the employer.

Most of the problems handled by the Board have been concerned with persons registered under other classifications of the Drugless Practitioners Act who may be

²⁴R.S.O. 1960, c. 114, s. 6, as amended by S.O. 1961-62, c. 36, s. 1.

²⁵O. Reg. 377/61, s. 17.

holding themselves out as physiotherapists, or with persons practising as physiotherapists who are not registered under any classification. If the Board is made aware that a person registered under another classification of the Drugless Practitioners Act is holding himself out as a physiotherapist, the Board sends a warning letter to the offender. If the warning is not heeded and the offender continues his practice, the Board of Directors of Physiotherapy advises the Board under which the offender is registered, and requests reports on any disciplinary action taken against the offender. If the offender is not registered by any regulatory body in the health field and is practising as a physiotherapist, the Board must prosecute him before a criminal court. However, as the Board maintains a close relationship with hospitals, it is not likely that anyone would be employed as a physiotherapist without being registered.

Proposed Regulatory Arrangements

As outlined in other chapters of this Report and particularly in Chapter 25, the Committee believes that many health disciplines should no longer continue to be self-governing but should come under the control of a general provincial regulatory body, the Health Disciplines Regulation Board.

Representations were made to the Committee by physiotherapists and by the College of Physicians and Surgeons of Ontario that the regulation of physiotherapists should be removed from the jurisdiction of the Drugless Practitioners Act, and that separate legislation should be enacted to govern them. The Committee agrees that the Drugless Practitioners Act is obsolete. However, the Committee does not agree that physiotherapists should be self-governing but rather is of the view that they should be licensed by the proposed Health Disciplines Regulation Board. The establishment of the licensing and discipline procedures of physiotherapists would be in accordance with the arrangements outlined in Chapter 25 and in the following recommendations.

Recommendations:

- 206** That physiotherapists be licensed by the Health Disciplines Regulation Board, through a Physiotherapy Division of the Board.
- 207** That the Health Disciplines Regulation Board attempt to develop standards of licensure for physiotherapists which could be recognized by other provinces in Canada and promote nation-wide recognition of standards for the greater mobility of physiotherapists.
- 208** That the Health Disciplines Regulation Board be empowered to license as physiotherapists, persons who have received training in physiotherapy outside Ontario, equivalent to that given in Ontario, and that the Board should determine such equivalents.
- 209** That physiotherapists educated in Ontario at educational institutions with accredited physiotherapy programs, who have completed such practical experience as may be required by the Health Disciplines Regulation Board, be automatically licensed without further examination.

- 210** That if, as a result of further studies of the role of physiotherapists, the need for physiotherapy technicians is established, such technicians should also be licensed by the Health Disciplines Regulation Board.

Occupational Therapists

History

The development of occupational therapy in Canada also was associated with the need to rehabilitate wounded veterans at the end of the First World War. The first training courses were established by the Canadian Military Hospitals Commission and were given at the University of Toronto. During 1918-1919, 375 "aides" were trained to serve in military hospitals across Canada, but the courses were discontinued after that time.

In 1921 the Ontario Society of Occupational Therapists was established by provincial charter and in 1926 on the request of Dr. Alexander Primrose, Dean of the Faculty of Medicine and Chairman of the Medical Committee of the Ontario Society of Occupational Therapy, the first course in occupational therapy leading to a diploma was established at the University of Toronto under the Department of University Extension. This course consisted of two years of academic preparation and eight months' internship.

In 1946, the course was extended to three years with an additional ten months of clinical experience required, and in 1950 was transferred to the jurisdiction of the Faculty of Medicine and combined with physiotherapy.

Thereafter the Canadian Association of Occupational Therapists, which had been established in 1934 as a national voluntary association, has required four months of clinical occupational therapy experience, two in psychiatry and two in physical disabilities, in addition to the four-month internship required by the Canadian Physiotherapy Association, before the graduate is eligible for membership in both associations.

In 1959 the Canadian Association of Occupational Therapists established a school in Kingston, Ontario for the training of occupational therapists in an attempt to overcome the problem of manpower shortages in this field. The course was of eighteen months' duration and required a university degree, teaching diploma or registration as a nurse for admission. Teaching staff for the medical subjects was obtained from the Faculty of Medicine at Queen's University. This course was discontinued in 1967 when Queen's University established a three-year diploma program in occupational therapy.

Role

Occupational therapy has been defined by the Canadian Association as "medically directed treatment using normal activities for the restoration of physical and mental functions, maintenance and improvement of existing healthy functions,

exploration of latent abilities, diagnostic assistance; and assessment of the emotional, mental and physical capabilities of a patient. The activities are those of work, re-education, recreation, inter-personal relationships, activities of daily living, self-help devices."²⁶

Examples of the actual work of occupation therapists include the following: teaching of skills regarding preparation of food and other activities of daily living, manual skills and creative arts such as woodwork, ceramics, and so on, to provide psychological support or specific group muscle action for patients with physical disabilities; industrial and pre-vocational activities; recreation and remedial games; the use of play therapy for children; and where no educational officer may be present, assistance in school subjects for hospitalized children or study of appropriate correspondence courses for adults.

As well as being involved in active treatment of patients, occupational therapists are required in administration, coordination of programs and teaching. They are employed primarily in institutional settings, such as rehabilitation departments of both general and mental hospitals, in convalescent hospitals and special workshops, and by special services such as Crippled Children Centres and Rehabilitation Institutes.

Manpower

As there are no licensing or registration requirements for occupational therapists, there is some difficulty in determining exactly how many of these therapists are located in Ontario, particularly the number who are qualified but not employed.

The Canadian Association of Occupational Therapists estimates that approximately 72 per cent of the occupational therapists practising in Ontario are members of the Association.²⁷ Ontario membership in 1969 was 358 active and 286 inactive.²⁸ In the same year the Ontario Association reported 591 members, 333 active and 258 inactive.²⁹ Table 16.2 shows the number of occupational therapists

TABLE 16.2

Number of Occupational Therapists Employed in Hospitals in Ontario, 1967-1968

	Full time	Part time
Public general hospitals (1968)	125	13
Public special hospitals (1968)	78	17
Mental hospitals (1967)	163	15
Tuberculosis hospitals (1967)	1	1
Total	367	46

SOURCE: See Chapter 6, Table 6.53.

²⁶Canadian Association of Occupational Therapists, reply to Questionnaire "B", Committee on the Healing Arts.

²⁷*Ibid.*

²⁸R. D. Fraser, *op cit.*, Table A175.

²⁹*Ibid.*, Table A176.

employed in hospitals. These figures include persons working as occupational therapists, whether or not they have fulfilled the educational qualifications required for membership in the voluntary association.

There are no accurate figures as to the number of qualified occupational therapists employed in all agencies in Ontario, and thus it is difficult to quantify any shortage of such personnel. There is a high turnover of occupational therapists.³⁰ This is a result of the prevalence of female personnel in this field who leave the profession for marriage and child-rearing, and the high percentage of therapists trained in other countries who may stay in Ontario only a short time. The establishment of further facilities for training more therapists is impeded by lack of qualified teachers.

In order to overcome some of these deficiencies it would be advantageous if more men could be attracted to the profession, and if increased attention were given to the effect of salaries and working conditions upon the numbers entering this field.

Recommendation:

- 211** That improved salary schedules for occupational therapists be developed by the Ontario Hospital Services Commission in order to encourage more persons to enter occupational therapy, and that greater efforts be made to recruit more men into this occupation.

Education

There are only two occupational therapy courses available in Ontario, one at the University of Toronto and the other at Queen's University. Both are diploma courses of three years' duration and the one at the University of Toronto is combined with physiotherapy.

Queen's University anticipates that eventually its program will be replaced by a four-year degree program, although no final plans have been made regarding this change.³¹ For the time being graduates from the Queen's diploma program, after completing two additional years of clinical practice, are eligible to apply to undertake an additional year leading to a Bachelor of Science in Occupational Therapy. No students have as yet been eligible for this program.

The University of Western Ontario is planning to introduce a program in occupational therapy in 1971 which will lead to the degree of Bachelor of Science in Medical Rehabilitation.

Accreditation of Canadian schools of occupational therapy is undertaken by the Canadian Association of Occupational Therapists jointly with the Canadian

³⁰Canadian Association of Occupational Therapists, Brief to the Committee on the Healing Arts, 1967, p. 11.

³¹Information received by the Committee on the Healing Arts in a letter from Queen's University.

Medical Association. The proposed outline of course content for new schools and alterations in established courses must be submitted for approval. Standards are set out in writing and include requirements regarding organization and administration, faculty, services and facilities, and content of the training program. Where the training program is jointly conducted for physiotherapists, the Canadian Physiotherapy Association is represented on the accreditation team.

The Committee approves of the development of university programs in occupational therapy and believes that these should be degree programs where possible. A second level of therapist could then be trained in a shorter period in Colleges of Applied Arts and Technology. While the Committee has not made a thorough study of the role to be played by such a second level occupational therapist, it urges that serious consideration be given to the establishment of a pilot project program for training such personnel in an appropriate College of Applied Arts and Technology, preferably one already offering programs for other health personnel with access to the necessary teaching staff and clinical facilities required. University programs in occupational therapy should then be designed to produce personnel for administration, teaching and research, and postgraduate work in occupational therapy should be made available in at least one university in Ontario as soon as possible.

Recommendations:

- 212** That at least one pilot project for educating occupational therapists in a program offered in an appropriate College of Applied Arts and Technology be undertaken, and that immediate studies be made by the Department of Health and the Council of Health on the role of occupational therapists trained in such programs, and their contribution to the health system. When such a course is introduced, an Educational Advisory Committee should be appointed to advise the Minister of Education on such matters as curriculum, and length of program, as outlined in Chapter 26.
- 213** That encouragement be given to the development of degree programs for occupational therapists at universities in Ontario presently teaching other health disciplines.
- 214** That a graduate program in occupational therapy should be established as soon as possible in at least one university in Ontario.

The Committee does not believe that compulsory programs for ensuring continuing competence of occupational therapists are essential. As the majority of occupational therapists are employees, there is supervision of their work on a day-to-day basis; and as in the case of nurses, the employer will be concerned that the therapist is maintaining her skills. We would encourage employers to make available appropriate opportunities to their employees to update their knowledge, and suggest that educational institutions make available continuing education programs. We also believe that refresher programs should be available. This would

enable occupational therapists who are not in practice to be brought up to date on recent developments and to have the opportunity to refresh themselves in the appropriate skills before re-entering employment.

Recommendation:

- 215** That refresher programs be made available for occupational therapists through educational institutions in order to attract into employment some of the qualified occupational therapists not now in practice.

Separation of Occupational and Physiotherapy Programs

Until the establishment of physiotherapy programs at Queen's and the University of Western Ontario, the only program offered was that at the University of Toronto, which was a combined course with occupational therapy.

Representatives from the voluntary associations representing occupational and physiotherapy favoured separation because graduates usually practise in only one of the two fields.³² They believed that time spent in learning techniques of the occupation which the student does not plan to practise might be more profitably used in acquiring more detailed knowledge in the chosen field. By trying to participate in both fields in a common program during a three-year period, the student has little opportunity to take courses outside his field and is not able to study in depth any aspect of one or either of the therapies. The Committee heard from one employer, however, who indicated that he favoured the dually educated graduates, as he found that they were more versatile in the working situation.³³

We believe that the student would receive greater benefit from being able to specialize in one or other program at the undergraduate level, although both programs might be offered by a school of health therapy within the health sciences complex.

Recommendation:

- 216** That programs in physiotherapy and occupational therapy be separated with some basic courses taken together where appropriate, and that both programs be offered within a school of health therapy within a health sciences centre where feasible.

Regulation

Occupational therapists in Ontario have not been subject to any provincial regulation up to the present time, and no licence or certificate is required for the practice of occupational therapy in the province. However, membership in the Canadian

³²Ontario Society of Physiotherapy, Brief to the Committee on the Healing Arts, 1966, p. 2. Also Canadian Association of Occupational Therapists, Brief to the Committee on the Healing Arts, 1966, p. 12.

³³Canadian Arthritis and Rheumatism Society, Transcript of the Hearings of the Committee on the Healing Arts, February 14, 1967, p. 334.

Association of Occupational Therapists designates a qualified occupational therapist and only those who are members in the national association are eligible to belong to the Ontario Society of Occupational Therapists, a provincial society of the national organization.

Since the Canadian Association does not bestow a special title on its members, in the working situation it is not evident who may or may not be a member of the Association. Eligibility for membership includes satisfactory completion of a course in occupational therapy accredited by the Association and fulfilment of a four-month internship. Applicants for membership from countries where there is not a national professional association which is a member of the World Federation of Occupational Therapists³⁴ (to which the Canadian Association belongs) must have their course of training in occupational therapy approved by the Federation.

The Canadian Association in its brief to the Committee pointed out that the lack of control and regulation of occupational therapists has enabled unqualified persons to function under the guise of professional occupational therapists. This, it believes, has led to detrimental patient care and a gross misinterpretation of occupational therapy.³⁵ The Association submitted that

... legislation be enacted which would empower a recognized official body of the profession to act as a regulatory body. Since licensing is provincial, it would appear that the Ontario Society of Occupational Therapists would be the appropriate regulatory body of the profession in Ontario.³⁶

We have not accepted this submission; for, as we have stated in Chapter 25, we do not believe that a voluntary association should be given regulatory powers.

We also do not believe that occupational therapy would easily lend itself to a licensing procedure or that licensing is necessary. There are some components of occupational therapy which in certain situations can be carried out by persons other than qualified occupational therapists, and the Committee does not wish to see the public deprived of the usefulness of these persons as they appear to perform a useful service.

It would, however, be possible and, in the Committee's view, advantageous to establish official certification of occupational therapists who have met established standards. Certification would assist health planning agencies in locating and determining where professional occupational therapists are working, would assist employers in determining the competence of applicants, and could to some degree make this occupation more attractive to prospective trainees.

³⁴The World Federation of Occupational Therapists is an international organization of occupational therapists, the members of which are the recognized national associations of occupational therapists in each member country. The Federation establishes standards of education which will be accepted internationally and approves schools which meet these standards.

³⁵Canadian Association of Occupational Therapists, Brief to the Committee on the Healing Arts, 1966, p. 16.

³⁶*Ibid.*

As in the case of other therapists, certification should be responsibility of the proposed Health Disciplines Regulation Board through an Occupational Therapy Division of the Board, as discussed in Chapter 25.

Recommendation:

217 That occupational therapists be certified by the Health Disciplines Regulation Board through an Occupational Therapy Division of the Board.

Remedial Gymnasts

History

While the First World War led to the development of physiotherapists and occupational therapists, the Second World War saw the emergence of a new group in the therapy field known as remedial gymnasts. This group, while never large in Ontario, does play an important role in specific aspects of physical rehabilitation.

The first remedial gymnasts were usually physical training instructors in the armed forces where they had received additional training in remedial exercise and recreational therapy under medical direction. After the war they were employed in casualty training and physical conditioning programs by the Department of Veterans Affairs. This Department held four courses after the Second World War in remedial exercise and recreational therapy to ensure standardized training of the gymnasts.

Since that time, the only other programs in Ontario for training gymnasts have been conducted by the Ontario Workmen's Compensation Board. Physical medicine departments of general hospitals and other medical institutions where remedial gymnasts are employed usually provide on-the-job training.

Role

The remedial gymnast employs basic skills in physical education and recreational therapy to aid in the restoration of the sick and disabled. There are two main aspects of the gymnast's work. There is remedial gymnastics, the scientific application of body movements in the treatment of disease and malfunction, usually performed in a gymnasium or similar atmosphere. There are also recreational activities, either therapeutic—physical activities originating from a medical prescription—employed on an individual or group basis in which competitive team games are used to recreate or redevelop maximal mental and physical functions; or social, which, in many cases, are undertaken by recreational therapists rather than remedial gymnasts and include activities to provide personal contact among patients such as film shows, group contests, supervised supportive therapy through crafts. Only in smaller institutions are remedial gymnasts concerned with this latter aspect of recreation for the patients.

Both therapeutic recreation and remedial gymnastics are intended to hasten the healing process and to create a level of physical efficiency in a patient to overcome, or compensate for, any physical disability. The treatments may also serve to prevent or minimize physical deterioration as a result of atrophy associated with old age, illness, injury or convalescence.

Remedial gymnasts work on medical prescription and are under the general supervision of physicians, or in some cases physiotherapists.

The remedial gymnast — as contrasted with the physiotherapist, who works with individuals — works primarily with groups, and utilizes equipment usually associated with a gymnasium, rather than specialized therapy equipment required by physiotherapists. In the past there have been some disagreements between these two disciplines. The Ontario branch of the Canadian Physiotherapy Association indicated to this Committee that physiotherapists would be prepared to carry out remedial gymnastics if required.³⁷ Physiotherapists are not specifically trained in this field, however, and it would appear to be an underutilization of the talents of more highly trained physiotherapists if they were to concentrate in this rather limited area.

The Committee received a number of letters from physicians testifying to the usefulness and importance of remedial gymnasts in health care, and supporting the gymnasts' request for the establishment of training facilities in Ontario for remedial gymnasts.

We do not think it advisable to encourage the unnecessary proliferation of new groups in the healing arts; and we believe that if a second level physiotherapist or physiotherapy technician is developed, the educational programs for such personnel could include training in remedial gymnastics with opportunities to specialize in this field also being made available.

Recommendation:

218 That remedial gymnastics be recognized as an important aspect of rehabilitative therapy and that encouragement be given to the teaching of remedial gymnastics in educational programs for physiotherapists or physiotherapy technicians as appropriate.

Whether or not the remedial gymnasts and physiotherapy technicians can be combined, a continuing supply of persons equipped to perform remedial gymnastics should be ensured.

Manpower

The number of remedial gymnasts in Ontario is very small. In 1966 there were thirty-two remedial gymnasts employed in rehabilitation centres and hospitals in Ontario.³⁸ The 1967 membership of the Association of Remedial Gymnasts was thirty-six.³⁹ All except one of these were male and twenty-one worked in Metropolitan Toronto. Most of the remedial gymnasts now practising in Ontario received their training while in the armed services or are ex-service personnel.

³⁷Ontario Branch, Canadian Physiotherapy Association, Transcript of the Hearings of the Committee on the Healing Arts, April 11, 1967, p. 2477-2479.

³⁸Information received directly from the Association of Remedial Gymnasts of Ontario.

³⁹See Table 6.3, Chapter 6.

The one training program for remedial gymnasts conducted by the Workmen's Compensation Board was held in 1967 and produced only four graduates. There is one school in England, Penderfield's Hospital, which trains remedial gymnasts and a few graduates of the course are now practising in Ontario. Most of the remedial gymnasts now practising in Ontario, however, were trained shortly after World War II and are approaching retirement age.

A questionnaire of the Association of Remedial Gymnasts of Ontario sent in 1968 to general hospitals in Ontario requested the requirements of these hospitals for remedial gymnasts until 1972. Replies indicated that fifty-one more remedial gymnasts might be utilized by these institutions, in some cases, however, only if the rehabilitative programs in these institutions were expanded. Gymnasts might also be valuable adjuncts to therapy programs in psychiatric hospitals as well, an area in which they have not been used in Ontario.

Education

As mentioned above, no formal educational program is available on a continuous basis for training remedial gymnasts in Ontario. The six-month program conducted by the Workmen's Compensation Board in 1967 has not been repeated. Other employers usually select persons who have some experience or interest in physical training or persons with training in massage for on-the-job instruction in remedial gymnastics. The Association of Remedial Gymnasts of Ontario believes that such a system is unsatisfactory and produces only semi-trained practitioners who would be of little value to any other employer.⁴⁰ The Association requested that a course be established in Ontario which would be comparable to that offered in Great Britain and which should be based in a hospital or rehabilitation centre.

The course offered at Penderfield's Hospital in Great Britain is three years with the third year consisting of practical experience and an internship. Those who have had a course of training in physical education or in the armed forces may complete the course in one year.

The Committee believes that any training program for remedial gymnasts as for other health therapists should be under the control of the Department of Education. As the development of education programs for remedial gymnasts should be coordinated with other programs for health therapists, we recommend the establishment of a Health Therapy Education Advisory Committee advisory to the Minister of Education. Such a Committee would be composed of knowledgeable persons from remedial gymnastics, massage therapy, hospital associations, the Department of Health and the Department of Education. This Committee should make recommendations on appropriate entrance requirements, course length, optimum curriculum and the establishment of pilot projects for new types of education programs for health therapists.

⁴⁰Association of Remedial Gymnasts of Ontario, Brief to the Committee on the Healing Arts, 1966, para. 72.

The development of a coordinating agency on such educational matters could also eliminate duplication and overlap of training programs. The Health Therapy Education Advisory Committee should work in conjunction with the Ontario Council of Health to ensure that manpower requirements continue to be met, and that the education programs are designed to prepare health therapists for their appropriate roles. We suggest that such education programs be conducted in Colleges of Applied Arts and Technology. In order to ensure a continuing supply of persons trained in remedial gymnastics we recommend that at least one educational program for remedial gymnasts be established in an appropriate College of Applied Arts and Technology. We believe that the entrance requirement for such a course should not exceed grade twelve from any secondary school program and that the course should be not longer than two years. Provision should also be made for those who have been trained in physical education or received such training in the armed forces to enrol in this program with appropriate credits given for their previous training.

Recommendations:

- 219** That the control of education programs for remedial gymnasts be under the Department of Education.
- 220** That a Health Therapy Education Advisory Committee be appointed, advisory to the Minister of Education, composed of persons knowledgeable in the fields of remedial gymnastics and massage therapy, from hospital associations, the Department of Health and the Department of Education and which would make recommendations regarding entrance requirements, course length and establishment of new programs in health therapy in educational institutions such as Colleges of Applied Arts and Technology.
- 221** That a pilot project be established for the training of remedial gymnasts in an appropriate College of Applied Arts and Technology.

Regulation

There is no provincial regulation of remedial gymnasts at present. The voluntary association, the Association of Remedial Gymnasts, was founded in 1958. Eligibility for membership includes graduation from an authorized training school although no specific school is named. In the Association's submission to this Committee during our hearing with the Association, the Association requested to be established as the licensing and regulatory body of remedial gymnasts.⁴¹

We believe that the Association's request should be refused and that, instead, remedial gymnasts should be regulated and certified by the proposed Health Disciplines Regulation Board through a Remedial Gymnasts Division. The practice of

⁴¹Association of Remedial Gymnasts of Ontario, Brief to the Committee on the Healing Arts, 1966, para. 21; Association of Remedial Gymnasts of Ontario, Transcript of the Hearings of the Committee on the Healing Arts, April 10, 1967, p. 2364.

such registrants would be limited to remedial gymnastics upon medical prescription. All those who are presently members of the Association of Remedial Gymnasts should be eligible for certification under this classification and there should be persons representative of remedial gymnastics on the Remedial Gymnasts Division of the Health Disciplines Regulation Board, responsible for developing the standards of certification.

Recommendations:

- 222** That remedial gymnasts be certified by the Health Disciplines Regulation Board through a Remedial Gymnasts Division. Remedial gymnasts now eligible for membership in the Association of Remedial Gymnasts of Ontario should automatically be eligible for certification by the Board.
- 223** That remedial gymnasts should be limited to providing treatment only on the prescription of a physician or under the direction of a physiotherapist acting on the prescription of a physician.

As the Committee believes that the services of remedial gymnasts are important to rehabilitative care, we believe that there should be no financial impediment to receiving such services when they are required. Therefore, we recommend that payment for these services be included under publicly financed health insurance plans, whether provided on an inpatient or outpatient basis except when such services may already be covered by the Workmen's Compensation Board or the Department of Veterans Affairs.

Recommendation:

- 224** That remedial gymnastic services should be included for coverage under publicly financed health insurance plans as appropriate.

Masseurs

History

The technique of massage is European in origin. The date of its introduction into Ontario is unknown, but masseurs have been officially recognized in the province since 1925, when they were included in the groups to be regulated by the Board of Regents under the Drugless Practitioners Act.⁴² The regulations made under this Act allowed masseurs to administer massage treatments but not to diagnose or prescribe. Anyone over twenty-one years of age, of good character, who was actively practising massage on January 1, 1926 was automatically granted a licence upon application.

Amendments to the Act in 1944 grouped masseurs with physiotherapists under "minor classifications". They were then not allowed to undertake any treatment except on prescription of a medical doctor, osteopath, chiropractor or drugless therapist. They were also prohibited from attempting to make any adjustment

⁴²S.O. 1925, c. 49.

of the boney structures of the human body. Educational qualifications were established as completion of lower school examinations and graduation from a professional college of massage offering a nine-month course.

In 1952 amendments were passed to the Drugless Practitioners Act which provided for the establishment of separate Boards of Directors for each classification.⁴³ The Board of Directors of Masseurs was established in 1953 and regulations were published by the Board in 1955 which allowed all previous registrants to automatically be re-registered without fee.⁴⁴ The Board also established educational requirements and examination procedures for foreign graduates. The requirement that masseurs undertake treatments only on prescription no longer applied.

The first voluntary association, the Society of Registered and Remedial Masseurs of Ontario was established in 1936. A second association, the Ontario Association of Massage Therapy was founded in 1965 and its membership is limited to those practising medical massage upon prescription from a physician.

Two independent schools for training masseurs exist in Ontario. The first, the Canadian College of Massage and Hydrotherapy, was created in 1946; and the second, the Ontario College of Massage, was founded in 1951.

The Board of Directors of Masseurs has no direct jurisdiction over the schools, and graduates of both schools must pass the examination established by the Board before receiving a licence.

Role

The regulations under the Drugless Practitioners Act define the system of treatment that may be followed by masseurs as the treatment of persons by

. . . (a) kneading, rubbing and massaging of body without adjusting or attempting to adjust any boney structure thereof, (b) use of steam, electric light, vapour or fume baths, and (c) the use of thermal or ultra violet lamps.⁴⁵

However, in the Drugless Practitioners Act itself a drugless practitioner is defined as a person who

. . . practises the treatment of any ailment, disease, defect, or disability of a human body by manipulation, adjustment, manual or electrotherapy, or by any similar method.⁴⁶

As the definition in the Act overrides that in the regulations, an unregistered masseur could not be successfully prosecuted for practising massage unless it could be proven that he was treating a person suffering from an "ailment, disease, defect or disability of the human body". This in fact was the interpretation of the court when the Board of Directors of Masseurs brought an action against an

⁴³S.O. 1952, c. 25.

⁴⁴O. Reg. 12/55.

⁴⁵R.R.O. 1960, Reg. 120, c. 2 (3).

⁴⁶R.S.O. 1960, c. 114, s. 1 (b).

unregistered masseur who had given a massage to an inspector from the Board. As the inspector was not suffering from any ailment or disease, the accused was acquitted of practising massage without a licence.⁴⁷ The Board has indicated that this ruling has made it difficult for it to control the profession, as less than 30 per cent of massage treatments are for remedial or therapeutic purposes.⁴⁸

There are basically three different types of massage work. One is conducted in recreational clubs, steam baths, private practices, and so on, where the massage is undertaken primarily to increase muscle and skin tone and not for any therapeutic purpose. Usually the massage is used as a non-medically prescribed palliative for nervous tension or as a facet of a weight reduction program. The second type of massage is found within athletics, where masseurs may work as athletic trainers for sports associations or clubs, and where they may in some cases assess the nature of an injury and administer massage treatments as required for relief. The third kind of massage treatment, and the one with which this Committee is primarily concerned, is remedial or therapeutic massage, which is given on the prescription of a physician as part of a rehabilitation treatment program. The latter type of massage forms only a small percentage of all massage work carried out by masseurs and most masseurs have little if any, contact with other groups in the healing arts.

Those masseurs who wish to make a career of therapeutic massage may find difficulty in obtaining referrals from physicians. This is partially because masseurs as a group are not highly regarded by many physicians. Consequently some masseurs administer remedial massage work on their own without referral, and may also attempt to make a diagnosis for which they are not trained.

Masseurs who are members of the Ontario Association of Massage Therapy, however, have agreed to work only on referral from physicians. Most of the Association's members work in private practice while a few are employed by hospitals or other institutions.

Some masseurs receive referrals from chiropractors. However, members of the Ontario Association of Massage Therapy reject strengthening this alliance with chiropractors in favour of developing more favourable relationships with physicians.

Physiotherapists in some cases regard masseurs with disfavour, although the practice of physiotherapy, while more technologically sophisticated than massage, does include massage in which physiotherapists are trained. Masseurs, however, are prohibited by law from using most of the equipment commonly employed by physiotherapists, and utilize electrotherapy and hydrotherapy only as peripheral to massage. In some small communities in Ontario, masseurs may represent the only existing alternative to a full-time physiotherapist, although treatments by masseurs are not included for coverage by the Ontario Hospital Services Commission.

⁴⁷Board of Directors of Masseurs, Brief to the Committee on the Healing Arts, 1966, p. 1.

⁴⁸Estimate by Executive of Ontario Association of Massage Therapy and agreed to by the Board of Directors of Masseurs.

Manpower

In 1968 there were 386 registered masseurs in Ontario. Females account for approximately 35 per cent of the total. The majority of registered masseurs are located in the greater Metropolitan Toronto area.⁴⁹

The growth in this occupation has not been great in comparison with that experienced by most occupations in the health field. From 1953 to 1968, there was an overall gain of only eighty-nine registered masseurs. The Board of Directors of Masseurs estimates, however, that there are a great number of unregistered masseurs, as those who do not make therapeutic claims and who work in health clubs need not be registered.

It is also difficult to assess the demand for masseurs, particularly for therapeutic massage. The Committee did not find that there was any shortage of such personnel in relationship to the requirements for their services. This, however, may be partially due to the fact that as there is no functional differentiation of masseurs, those wishing to practise only medical massage have been unable to develop methods of upgrading their status and create a greater demand for their services among the general public or other health practitioners.

Education

There are at present two private institutions in Ontario, both located in Toronto, which teach massage. The length of program offered at each is nine months, with classes available in the evening for students who are employed during the day. Neither institution has clinical facilities for medical massage or is affiliated with a hospital. Neither has adequate library facilities or offers advanced studies. The teaching staff at both rarely have qualifications in excess of the minimum required for registration as a masseur. Both colleges are proprietary, profit-making businesses, which receive no public support and are not accredited by any public body.

Under the present regulations, the Board of Directors of Masseurs has established educational requirements for eligibility to write the Board registration examinations.⁵⁰ Current requirements are grade ten, the completion of a course of instruction which meets the requirements of the regulations, and good moral character. Prior to 1958, a minimum of grade twelve was required and the representatives of the Board and the two voluntary associations in their submissions to this Committee requested that entrance requirements should again be increased to grade twelve in order that students in massage schools would be able to understand better the required subjects.⁵¹ According to the regulations, the courses offered should expose the student to 540 hours of theoretical subjects and 500

⁴⁹Information supplied by the Board of Directors of Masseurs.

⁵⁰R.R.O. 1960, Reg. 122, s. 14 (2) and s. 23.

⁵¹The Ontario Association of Massage Therapy, Brief to the Committee on the Healing Arts, 1966, p. 2; Board of Directors of Masseurs, Brief to the Committee on the Healing Arts, 1966, p. 7; the Society of Registered and Remedial Masseurs of Ontario, Brief to the Committee on the Healing Arts, 1967, p. 3.

hours of clinical experience. The directors of both the schools of massage agreed that it was impossible to fulfil this requirement in a nine-month course conducted during the evenings and stated that the Board has interpreted these requirements quite liberally, allowing students to include time spent on homework as part of required hours of instruction.

Both schools charge approximately \$350 for the course, not including texts. Based upon our inquiries, we do not believe that the present schools should be accredited for the teaching of masseurs who may be permitted to undertake massage therapy under the system of regulation we shall propose later in the chapter. Such massage therapists should instead be trained in institutions under the jurisdiction of the educational authorities of the province. We suggest that a program be established for massage therapists in an appropriate College of Applied Arts and Technology. With the introduction of such a program, we hope that the standard of applicants would improve and the practice of massage therapy by qualified massage therapists would be accepted by physicians and other health service personnel as an appropriate and necessary health service for some types of illnesses and physical disorders.

In an attempt to raise the standards of recruits the Committee believes that the entrance requirements for the program should be grade twelve, and that the training program should be not less than one year and not more than two years. We also believe it advisable that one College of Applied Arts and Technology should establish a general program in health therapy with options for students to specialize in massage therapy, remedial gymnastics, or hydrotherapy.

The Committee was not favourably impressed by the programs offered by the present schools of massage or by the qualifications of the teaching staff, and does not believe that the schools are providing services which should receive any type of financial support from the province. Even for masseurs practising outside the health field, it might be better to place training programs in publicly supported institutions.

Recommendations:

- 225** That at least one educational program for massage therapists should be introduced in an appropriate College of Applied Arts and Technology and that the Health Therapy Educational Advisory Committee should advise the Minister of Education on the length of the program, entrance requirements, and related matters.
- 226** That once training programs in massage therapy are introduced under the jurisdiction of the Department of Education, only masseurs educated in such approved programs be eligible for licensing as massage therapists by the Health Disciplines Regulation Board.
- 227** That the Health Therapy Educational Advisory Committee should immediately study the appropriateness of establishing at least one program

in a College of Applied Arts and Technology for training health therapy technicians with opportunities for the students to specialize in remedial gymnastics, massage therapy or hydrotherapy.

Regulation

As stated above, masseurs are presently regulated by the Board of Directors of Masseurs under the authority of the Drugless Practitioners Act. The members of the Board are appointed by the Lieutenant Governor in Council, for a two-year period, usually upon the recommendation of the Society of Registered and Remedial Masseurs of Ontario. Membership on the Board has been relatively static over the last decade, and none of the members has been in the practice of purely medical massage.

The control and discipline of masseurs have created difficulties for the Board, which has been criticized both for its action and for its lack of action in maintaining standards among masseurs. The Board submitted to the Committee that as the present legislation does not require that any person who does massage work for gain be licensed, it is very difficult for the Board to enforce what it believes to be the intent of the legislation.⁵² The Board, for example, is not able to discipline licensed masseurs for hiring unlicensed masseurs to work for them as long as they do not massage a person suffering from an ailment, a situation which has led to allegations that in at least one instance a registered masseur kept a common bawdy house and hired unregistered persons who engaged in prostitution in the guise of masseuses.⁵³ In fact in reviewing the disciplinary cases brought before the Board from 1964 to 1966, the most common charges were those involving procuring, keeping a common bawdy house, and being charged as a "found-in".⁵⁴ This type of conduct among some masseurs has brought the reputation of all masseurs into disrepute.

We have indicated above that only a small portion of masseurs practise medical massage. It would appear appropriate, therefore, that masseurs who do not practise medical massage should not be regulated under health legislation, but that the administration of regulatory requirements should come under another government agency such as the Department of Labour. Masseurs who wish to practise massage therapy would be the only masseurs to be considered practitioners in the health field and they should be licensed by the proposed Health Disciplines Regulation Board through an appropriate Division. Only masseurs educated in approved programs would be eligible for licensing, and they would be required to practise on the prescription of a qualified physician or under the direction of a registered physiotherapist, and to practise within the definition of massage therapy as outlined in the following recommendations. The Massage

⁵²Board of Directors of Masseurs, Brief to the Committee on the Healing Arts, 1966, pp. 4-5.

⁵³*Ibid.*, p. 4.

⁵⁴Letter from the Board of Directors of Masseurs to the Committee on the Healing Arts, March 1967.

Therapy Division of the Board should not automatically license as massage therapists any masseurs presently registered by the Board of Directors of Masseurs. Instead the Division should review the qualifications of each applicant and ensure that everyone granted a licence is properly qualified to practise massage therapy.

The Committee recommends strict measures for this particular group. Even those masseurs who meet the qualifications for the proposed massage therapist should be under strict supervision by the Massage Therapy Division of the Health Disciplines Regulation Board in order to prevent the type of disciplinary problems which have arisen among existing masseurs, and in the hope that eventually this group may receive the approbation of others in the health field.

Our proposals would result in the development of two types of masseurs. The first, non-medical masseurs, whose education and practice should be controlled by a government agency other than the Department of Health; the second, massage therapists who would provide remedial massage treatments only on prescription of physicians, and who would be educated in provincially supported educational institutions and licensed by the Health Disciplines Regulation Board.

Recommendations:

- 228** That the present Drugless Practitioners Act be repealed and the Board of Directors of Masseurs abolished, and that the regulation of general masseurs be transferred to a government department or agency, other than the Department of Health, but that those masseurs who wish to provide massage therapy be required to be licensed by the Health Disciplines Regulation Board through a Massage Therapy Division.
- 229** That masseurs presently registered by the Board of Directors of Masseurs should not be eligible for licensing automatically by the Health Disciplines Regulation Board, but that the Massage Therapy Division should examine the qualifications of each applicant and, where necessary, establish examinations or arrange for further training of applicants to ensure they have adequate qualifications to provide massage therapy services. Those masseurs licensed by the Health Disciplines Regulation Board should be designated as massage therapists and limited to the system of treatment of massage therapy as defined in Recommendation 231 and permitted to provide massage therapy only upon the prescription of a qualified physician or under the direction of a registered physiotherapist who has received such a prescription.
- 230** That persons trained in massage therapy outside Ontario, but who have qualifications similar to those required in Ontario, be licensed by the Health Disciplines Regulation Board despite a lack of prerequisite education prior to completion of educational programs in massage therapy.
- 231** That the system of treatment that may be carried out by a massage therapist be defined as the treatment of persons by (a) kneading, rubbing

and massaging of the body without adjusting or attempting to adjust any boney structure thereof, (b) use of steam, electric light, vapour or fume baths and (c) the use of thermal or ultraviolet lamps.

In keeping with our recommendations regarding coverage of services under health insurance plans, the Committee also believes that where essential massage treatments are prescribed by a physician, the costs should be covered by publicly financed health insurance plans, whether the treatments are given by a physician, massage therapist, or other practitioner qualified to give such treatments.

Recommendation:

232 That massage therapy treatments prescribed by a qualified physician and given by a licensed massage therapist, a physiotherapist, or other practitioner qualified to give the treatments, be covered by publicly financed health insurance plans.

Hydrotherapy

While it could not consider cases of individual hardship, the Committee did receive representations on behalf of the privately operated Hyland Institute in London, Ontario. The Patients' Committee for this Institute recommended that the types of treatment given at the Institute should receive greater recognition by the medical profession and be incorporated as part of the course of training for physiotherapists.⁵⁵

The Committee was favourably impressed by the information submitted by the Patients' Committee and by other members of the public, including several orthopaedic physicians in the London area,⁵⁶ as to the merits of the treatments employed in this Institute. These consist of intensive hydrotherapy treatment, including the use of a deep water pool and underwater traction. Treatment programs are personalized and treatment sessions may last from two to five hours, a much longer period than those usually given by other health therapists.

While we did not undertake a scientific evaluation of these treatment methods, we do believe that the possible advantages of this type of treatment may have been overlooked by physiotherapists and psychiatrists, and that a more thorough and sympathetic study should be made of such methods. We also concluded that hydrotherapy should be included in the curriculum of studies of health therapists and that opportunities should be made available for persons to specialize in this field. (See Recommendation 227.) We would suggest that the facilities of the Hyland Institute might be utilized as a facility for teaching in these techniques.

One of the major difficulties faced by the Institute has been that the services provided are not eligible for coverage by health insurance. We believe that

⁵⁵The Patients' Committee of the Hyland Institute, Brief to the Committee on the Healing Arts, 1967, p. 1.

⁵⁶Letter accompanying Brief of the Patients' Committee of the Hyland Institute from Dr. J. C. Kennedy, Dr. John L. Felix and Dr. S. G. Vigh.

the recommendations we have already made regarding coverage of treatment by physiotherapists and masseurs should include treatments given at the Hyland Institute, which are always carried out on the prescription of a qualified physician.

A complicating factor is that the present owner of the Institute, who has been responsible for the institution of these special treatment methods in Ontario, does not meet the existing qualifications for registration as a physiotherapist although he is presently registered as a masseur. Under our proposed regulatory arrangements, however, he should be eligible for registration by the Health Disciplines Regulation Board either as a massage therapist or other appropriate category. We believe that the Board should be sympathetic to applications such as his where the "apparent" success in practice may be verified even if the formal academic qualifications may be difficult to assess.

The Committee realizes that the cost of individual treatments at the Institute is higher than those generally given by physiotherapists or masseurs, as the Institute's treatment sessions are considerably longer. However, we do not believe that we can suggest any special compensatory arrangements, and this matter should be worked out between the insuring agency and the Institute.

Speech Therapists and Audiologists

Speech therapists and audiologists are discussed together in this section for purposes of convenience only. The Committee realizes that each is a distinctive occupation, but as our recommendations regarding the education and regulation of both speech therapists and audiologists coincide, we have found it less repetitive to discuss them jointly.

History

Speech therapy and audiology have developed as recognized occupations only since World War II, while the conditions which they treat have been labelled as handicaps for many centuries. It was not until World War II when centres were established for the rehabilitation of veterans who had suffered service-connected hearing impairments, and speech handicaps, that programs were developed in universities in the United States for training of personnel in these fields. Then, in 1958, the University of Toronto commenced a two-year combined diploma course in speech pathology and audiology, the only program offered in Ontario.

There has been no state licensure or certification of either speech therapists or audiologists in Ontario. The Ontario Speech and Hearing Association was established in 1959 as a voluntary association for both groups. Minimum qualifications for full membership in the Association are a Master's degree in speech therapy or audiology. However, as no Master's degree program exists in Ontario at present, the organization has accepted persons holding the University of Toronto Diploma in Speech Therapy and Audiology as well as persons with the British L.C.S.T. (Licentiate in Speech Therapy). Graduates from universities in the United States, holding a Bachelor's, Master's or doctorate degree in speech therapy or audiology may be admitted after completing the Association's examinations.

Role

Speech therapy is concerned with a wide range of speech disturbances either in the use of language or in the use of voice which may result from paralysis of the central or peripheral nervous systems, laryngial conditions, congenital anomalies of the organs of speech, or emotional disturbances. The speech therapist is trained in problems relating to stammering, functional difficulties in articulation, delay in the proper use of language, reading difficulties, as well as problems related to deficiencies in hearing.

The second group of personnel in the speech field are speech correctionists. They are teachers, particularly at the public school level, who take special summer programs offered in speech correction by the Ontario Department of Education. Before enrolling in this program teachers must have three years of classroom experience and after completing the appropriate courses during three summer sessions, they may qualify as speech correctionists.

These teachers continue in their regular role as classroom teachers but with the basic training in speech problems which they have received, they are able more easily to detect children who have communication or reading problems due to speech impediments. The correctionists themselves may assist with problems such as accent difficulties, but the more difficult cases are referred to a qualified speech therapist or for medical assistance. As there are few qualified speech therapists employed by school boards, it is often difficult for children with speech disorders to obtain the necessary treatment, especially if the disorders are non-organic and the child cannot be referred to a hospital clinic.

One impediment to introducing more speech therapists into the school system is the present requirement that speech therapists must also be qualified teachers before they can be so employed. This usually requires one additional year's training at a College or Faculty of Education beyond the completion of the training in speech therapy.

The audiologist is a specialist in diagnostic evaluation, rehabilitative services and research related to hearing.⁵⁷ He must determine the range, nature and degree of hearing function, using electroacoustic instruments such as pure-tone speech audiometers and galvanic skin response equipment, all very specialized and expensive equipment. He coordinates the audiometric results with other diagnostic data such as educational, medical, social and behavioural information. Based upon the results he is able to recommend the type of assistance which should be most successful for the patient.

The rehabilitative work done by audiologists includes counselling, guidance, auditory training, speech reading and speech conversation. The audiologist can and should provide counselling services to assist the patient to understand his problem and to be aware of the potentialities and limitations of a hearing aid, which often requires complex psychological adjustment.

⁵⁷U.S. Department of Labour, *Dictionary of Occupational Titles*, 1965 edition.

Audiological research is conducted in the fields of physiology, pathology, biophysics and psychophysics of auditory systems.

While the audiologist has a close relationship with speech pathology, he is also an offspring of otology, a medical specialization concerned with the diagnosis and treatment of individuals who have an ear disease or disorders of the peripheral mechanism of hearing. In the working situation the audiologist often has a closer relationship with an otologist than with the speech therapist, as it is the otologist who, upon diagnosing a hearing problem, will refer a patient to the audiologist for further testing and measurement of hearing loss.

Speech therapists are employed by hospitals, boards of education and private speech clinics. Audiologists may be employed by hearing centres, rehabilitation centres, hospitals, schools for the deaf or private clinics, and may also be found in private practice. In some cases an audiologist may have a formal relationship with otologists in a group practice where, on the request of the otologists, he evaluates the performance of hearing aids for patients, and then refers the patients to a hearing aid dispenser for an actual fitting. Ideally, all persons suffering a hearing loss for which a hearing aid may be required, should be tested by an audiologist in order that the most efficient type of device suited to the person's particular requirement is prescribed. However, since there are few audiologists in Ontario, their services are not readily available, and most persons requiring a hearing aid go directly to hearing aid dispensers.

Manpower

Speech Therapists

A survey undertaken in October 1966 by the Ontario Speech and Hearing Association revealed that at that time there were approximately seventy qualified speech therapists in Ontario practising in centres providing speech services. In addition, there were sixty-nine speech correctionists working in the school system and five speech therapists in private practice.⁵⁸

The 1968 membership list of the Ontario Speech and Hearing Association lists seventy-four full members and thirty-two associate members.⁵⁹

It is obvious that this number of speech therapists cannot begin to meet the demand for such personnel. Estimates have been made that 3 per cent of the population have speech disorders requiring treatment.⁶⁰ While these were studies in the United States, we have no reason to believe that Ontario's needs would differ greatly. To meet such a need and allocating each speech therapist a case load of 240 patients, 900 speech therapists would be required in Ontario at

⁵⁸Survey of Speech and Hearing Services in Ontario. A survey prepared for the Ontario Speech and Hearing Association, October 1966.

⁵⁹Chapter 6, p. 191.

⁶⁰F. E. Linder et al., "Impairments by Type, Sex and Age—United States, July 1957-June 1958", *Health Statistics*, U.S. Department of Health, Education and Welfare, Series B9, 9-13, Washington, D.C., 1959.

present. Even if persons suffering from emotionally based speech disorders could be treated by other types of practitioners, such as psychologists and psychiatrists, it is still evident that there is a great shortage of qualified speech therapists in Ontario.

The Research Committee of the Committee of Presidents of Universities of Ontario has also recognized the need for increased personnel in this field. It recommended a four-fold increase in student enrolment from fifteen in 1966-1967 to sixty-four in 1976-1977, with an annual graduating class of twenty-five.⁶¹

Because of the lack of speech therapists, few hospitals are able to offer speech services, and even within Metropolitan Toronto the majority of therapists are employed in the central part of the city with few services being offered in the outlying areas. Outside Toronto the situation is worse and North Bay, the only northern centre which has even attempted to offer hospital speech services, has had vacancies for speech therapists for nearly four years.

Audiologists

As there is no registration of audiologists, it is difficult to obtain accurate figures of the number of persons in this field. Our inquiries revealed only nine persons employed as audiologists in Ontario. Estimates given to the Committee indicate that approximately 10 per cent of the population suffer some degree of hearing loss, and that about 2 per cent require special assistance.⁶² It is obvious that in this area, too, there is a great need for more qualified personnel.

Recommendations:

- 233** That the Department of Health undertake a review of salaries and working conditions, and other factors affecting the recruitment and employment of speech therapists and audiologists to ensure that conditions are as conducive as possible to attracting greater numbers of personnel into this area of health services.
- 234** That speech therapists directing speech therapy programs in the school system not be required to qualify as classroom teachers, and that more teachers be trained as speech correctionists who could assist qualified speech therapists in the detection and treatment of speech disorders among school children.

Education

Only one program exists in Ontario for education of speech therapists and audiologists. This is a combined two-year diploma course offered at the University of Toronto under the Department of Rehabilitative Medicine within the Faculty of Medicine, which requires an undergraduate degree for entry, although under special circumstances graduates of non-degree courses may be admitted.

⁶¹Committee of Presidents of Universities of Ontario, *op. cit.*, p. 7.

⁶²Pharmacy, *Vision and Hearing Services*, *op. cit.*

One of the major complaints of speech therapists in Ontario has been that the program at the University of Toronto concentrates too heavily on the organic aspects of speech therapy, placing little emphasis on psychology and problems related to the emotional effects of speech problems.⁶³ As far as audiologists are concerned, their dissatisfaction stems from the minimal training offered in their specialty within the combined course. Less than one-third of the program is spent on courses relating to audiology and the graduates feel they are not prepared to enter this field without further training. Many of the programs offered at universities in the United States, whether combined programs or separate audiology programs, provide much more training in audiology particularly in the area of children's hearing disorders and teaching of speech and language to the deaf.

The Ontario Speech and Hearing Association is also dissatisfied with the present entrance requirements for the University of Toronto program. It believes that students entering the program should have completed an undergraduate degree program including courses related to the program such as physiology and psychology.⁶⁴

The numbers enrolled in this program are very small; the student enrolment for the 1969-1970 academic year was twenty-four. There have been eighty-one graduates in the ten graduating classes since the program began, with a decrease in the number of graduates from fourteen in 1968 to three in 1969.⁶⁵

Approximately half of the program is spent in clinical observation and experience, all of which is done in the second year. Clinical facilities are provided at the Wellesley Hospital, the Hospital for Sick Children and Toronto Western Hospital as well as at the school's own clinic.

The Ontario Speech and Hearing Association is also unhappy that the program does not lead to a Master's degree, and the Committee on Clinical Practice and Certification of the Association has proposed that a Master's degree program in speech therapy be developed at an Ontario university other than the University of Toronto.

The President's Research Committee of the Committee of Presidents of Universities of Ontario recommended that programs for speech therapy and audiology belonged in university health science centres and should have close relationships with the behavioural and neurological sciences.⁶⁶ However, that Committee did not comment on the advisability of continuing the combined course or of introducing an undergraduate program in speech therapy.

⁶³Ontario Speech and Hearing Association, Brief to the Committee on the Healing Arts, 1966, p. 6.

⁶⁴Ontario Speech and Hearing Association, Transcript of the Hearings of the Committee on the Healing Arts, March 13, 1967, pp. 1260-1261.

⁶⁵Information received directly from the Department of Rehabilitative Medicine, University of Toronto.

⁶⁶Committee of Presidents of Universities of Ontario, *op. cit.*, p. 13.

It is our view that new programs are urgently required for the training of both speech therapists and audiologists and that the logical place for such programs to be developed is within the university health sciences' centre. Where strong health science centres are developed we believe that speech therapy and audiology programs along with other health therapy programs should come under schools of health therapy within the centre. However, until such time as such schools of health therapy may be developed, the education of both speech therapists and audiologists should continue under the jurisdiction of the faculty of medicine. We recommend, however, that care be taken to ensure that no specialty within medicine dominates in the educational program of of speech therapists and audiologists and that there is adequate emphasis on the social and psychological aspects of the training as well as on physical medicine.

The Committee also believes that separate programs should be developed for speech therapists and audiologists, although we recognize that some courses within the separate programs might be taken together. At the same time, we recommend that undergraduate programs in speech therapy and audiology be introduced in Ontario universities teaching other health sciences. Subsequently, a postgraduate program leading to a Master's degree should also be instituted in at least one university offering an undergraduate program. It should be noted that the University of Western Ontario has announced that it intends to introduce an undergraduate program in speech therapy and audiology commencing in 1971. This program will lead to a Bachelor of Science degree in Medical Rehabilitation (B.Sc.M.R.).⁶⁷

The Committee does not foresee in the immediate future the development of Ph.D. programs in Ontario for these disciplines and thus it will be necessary for students to obtain further postgraduate training elsewhere, most likely in the United States. If in the future Ontario develops the expertise and personnel which would permit the development of a Ph.D. program within the province, we would certainly hope that encouragement and assistance would be given to such a venture and that appropriate monies would be made available for necessary research facilities.

Recommendations:

- 235** That separate undergraduate degree programs in speech therapy and audiology be developed as soon as possible in Ontario universities teaching other health sciences, and that these programs be included in a school of health therapy where developed; but where no school of health therapy exists, educational programs for speech therapists and audiologists should be taught within the Faculty of Medicine, with care taken to ensure that no medical specialty dominates in the development of the curriculum and that there is adequate emphasis on the social and psychological aspects of the training as well as on physical medicine.

⁶⁷*The University of Western Ontario News*, Vol. 5, No. 16, November 20, 1969

- 236** That, as soon as feasible, at least one university in Ontario which develops undergraduate degree programs in speech therapy and audiology, also establish postgraduate programs in speech therapy and audiology leading to a Master's degree.

It is our understanding that the present summer programs for speech correctionists sponsored by the Department of Education may eventually be included within the faculties of education being developed at various Ontario universities. We believe that the training of speech correctionists would more appropriately be done by those responsible for training speech therapists. Appropriate consultation would be required between those offering these programs and the faculties of education in order that teachers completing courses in speech correction would be given credit by their employers for this training. Students in the Bachelor of Education programs now being developed should also have an opportunity to take options in speech therapy, and these should be developed jointly by the faculties of education and by those responsible for teaching speech therapy.

Recommendation:

- 237** That special programs for training speech correctionists be established by university schools of speech therapy, and that such programs should be offered during the summer in order to make them available to teachers wishing to obtain special training in speech problems.

Continuing and Refresher Education

As for most other practitioners in the health field, the Committee recommends that programs for ensuring the continuing competence of speech therapists and audiologists should be introduced. A more detailed discussion of our proposals on this matter may be found in Chapters 25 and 26. As there is no Ontario accreditation of schools of speech therapy and audiology at present, we also recommend that the Ontario Council of Graduate Studies should make arrangements for the accrediting of both undergraduate and graduate programs which may be offered in Ontario, and that only accredited schools should be authorized to certify the continuing competence of practitioners.

Recommendations:

- 238** That a program for ensuring continuing competence be implemented for speech therapists and audiologists and that periodically, perhaps every five years, every speech therapist and audiologist in Ontario be required to present to the Health Disciplines Regulation Board a certificate from an accredited school of speech therapy or audiology in Ontario stating that he has maintained a satisfactory level of competence in the practice of speech therapy or audiology.
- 239** That the accredited schools of speech therapy and audiology in Ontario develop the standards and programs which would be required for such

certification and that the Ontario Council of Graduate Studies see that proper accrediting arrangements are made for accrediting schools of speech therapy and audiology.

Regulation

There is not, nor has been, any regulation of speech therapists or audiologists in Ontario.

The Ontario Speech and Hearing Association has proposed that legislation be enacted to register speech pathologists and audiologists, and that the Association should be the registering body.⁶⁸ The Canadian Hearing Association also submitted that the Ontario Speech and Hearing Association be made the certifying and disciplinary body for audiologists.⁶⁹

We agree that certification would provide a means whereby the public could identify those speech therapists and audiologists who met certain standards of qualification, and would also assist in upgrading the status of these groups. However, as with many other disciplines, we believe that the certification program should be under the jurisdiction of the proposed Health Disciplines Regulation Board. At this time only certification should be introduced, as there does not appear to be a need to license these practitioners. Appropriate Divisions for speech therapy and audiology should be established by the Board for the development of initial standards for certification as discussed more fully in Chapter 25. Certification should be granted to graduates of an approved graduate or undergraduate program.

We are aware that this standard for certification will be lower than the Master's degree required for membership in the American Speech and Hearing Association. However, we believe that speech therapy and audiology may appropriately be taught at the undergraduate level, and that only if such programs are developed can our requirements for these practitioners be met.

Recommendations:

- 240** That speech therapists and audiologists be certified by the Health Disciplines Regulation Board through Divisions of the Board for speech therapy and audiology.
- 241** That the Health Disciplines Regulation Board accept for certification speech therapists and audiologists who have received their education in speech therapy or audiology outside Ontario, but whose education is equivalent to that given in Ontario.

Treatment Clinics

The Committee would like to see the services of speech therapists and audiologists made available throughout Ontario, not just within the larger metropolitan areas.

⁶⁸Ontario Speech and Hearing Association, Brief to the Committee on the Healing Arts, 1966, p. 5.

⁶⁹Canadian Hearing Association, Brief to the Committee on the Healing Arts, 1967, p. 4.

These services should be made available in conjunction with other general health services and the most appropriate means of providing them may be through the establishment of speech and hearing services in group practices, community health centres, or hospital outpatient departments. These centres might also be used as clinical facilities in the training of speech therapists and audiologists.

Recommendation:

- 242** That speech and hearing services should be provided throughout the province, preferably in conjunction with other health services, in clinics, group practices, or hospital outpatient departments where feasible.

Insurance Coverage

At present speech therapy and audiological services are not covered by publicly financed health insurance. We believe that the services provided by both of these groups are essential health services and should be covered if we are to prevent distortions in the provision of health care. However, in order to provide proper protection both to patients and the public, such payment should be made only to certified personnel and only if the patient has been referred to a qualified physician for a physical examination before treatment by the speech therapist or diagnostic evaluation by the audiologist.

Recommendation:

- 243** That essential health services provided by speech therapists and audiologists be included under publicly financed health insurance plans, but that only speech therapists and audiologists who are certified by the Health Disciplines Regulation Board be eligible for such payment. Payment by the health insurance authority should be made only if, before treatment by the speech therapist or diagnostic evaluation by the audiologist, the patient has been referred to a qualified physician for a physical examination to ensure there are no other attributing organic problems requiring medical treatment by a physician.

Hearing Aid Dispensers

Hearing aid dispensers are commercial vendors of hearing aids. They include both salesmen and dealers who often operate under a franchise for one or more hearing aid manufacturers. Most hearing aid dispensers provide a limited testing service but no formal training is required and the dispenser's knowledge of audiology is very limited.

There is at present no registration or licensing of hearing aid dispensers in Ontario, other than they may be required to hold a business licence in the community in which they are operating. During the early deliberations of the Committee, hearing aid dispensers were severely criticized in the press by customers who were not able to obtain the servicing promised, and by others who believed that the equipment which they had purchased had been misrepresented to them.

In 1967 members of the Hearing Aid Dealers Association of Ottawa, the Hamilton District Hearing Aid Dealers Association, and the Toronto Hearing Aid Dealers Association together formed the Ontario Hearing Aid Association. Membership in this Association represents more than 75 per cent of full-time dispensers in the province and in August 1969 there were 167 members.⁷⁰ Applicants for membership must have their competence certified by an otologist and must undertake to abide by a strict code of ethics which is enforced by the Association.⁷¹

The measures taken by this Association appear to have greatly assisted in decreasing the number of complaints from the public about hearing aid dispensers. From the period July 1967 to November 1968, the Consumer Protection Bureau of the Department of Financial and Commercial Affairs received only three justified complaints regarding members of the Association.⁷² During the six-month period ending January 31, 1969, the Better Business Bureau of Metropolitan Toronto had received only two minor complaints against members and two others regarding non-members.⁷³

The efforts of the Ontario Hearing Aid Association appear, therefore, to be meeting considerable success and we hope they will continue.

The Committee received requests from the Ontario Hearing Aid Association and the Canadian Hearing Society that hearing aid dispensers should be regulated under the jurisdiction of the Minister of Health. The Ontario Hearing Aid Association submitted that it become the certifying and disciplinary body,⁷⁴ while the Canadian Hearing Society suggested that a body with representatives from medicine, audiology and hearing aid dispensing be created as a certifying body for hearing aid dispensers, or that hearing aid dispensers create their own regulatory body, responsible to the Ontario Speech and Hearing Association.⁷⁵

However, the Committee did not receive convincing evidence that, insofar as competent adults were concerned, significant medical harm would result from a dealer improperly fitting a hearing aid. Most of the complaints regarding dispensers have centred on matters of price, misrepresentation or servicing and these in themselves are not directly related to health. While they are inconvenient to the purchaser, we do not believe that they would justify licensing of hearing aid dispensers under the Health Disciplines Regulation Board. Such licensing, if required, would more appropriately be considered under consumer protection legislation. We suggest, however, that in the sale of hearing aids for children under the age of twelve there should be an additional control on the hearing aid dispenser. Before any child under the age of twelve is fitted with a hearing aid,

⁷⁰Information supplied directly by the Ontario Hearing Aid Association, 1969.

⁷¹Ontario Hearing Aid Association, Brief to the Committee on the Healing Arts, 1967, p. 2.

⁷²Letter from the Consumer Protection Bureau, Department of Financial and Commercial Affairs, to Ontario Hearing Aid Association, November 12, 1968.

⁷³Direct communication with the Better Business Bureau of Metropolitan Toronto.

⁷⁴Ontario Hearing Aid Association, Brief to the Committee on the Healing Arts, 1967, p. 6.

⁷⁵Canadian Hearing Society, Brief to the Committee on the Healing Arts, 1966, p. 4.

the child should be referred to a qualified physician for a general physical examination to determine if there are other medical conditions which would contra-indicate the appropriateness of a hearing aid.

Recommendations:

- 244 That legislation be enacted to require that no hearing aid may be fitted or sold for a child under the age of twelve without a written prescription from a qualified physician, and that there be a mandatory referral of the child to the physician after the hearing aid is fitted.
- 245 That the regulation of hearing aid dispensers come within the purview of government agencies concerned with consumer protection legislation rather than health care legislation.

Chapter 17 Dietitians and Medical Record Personnel

This chapter is concerned with two groups in the health field: dietitians and medical record personnel. While neither group has much direct contact with patients, both play an important role in the administration of health services. Otherwise, there is little in common between these two types of health care personnel, and they are discussed in one chapter for convenience only.

Dietitians

Proper nutrition is an important element in the maintenance of good health, as well as in the treatment and rehabilitation of persons suffering from disease or disability. A diet lacking in essential vitamins or minerals can result directly in such diseases as scurvy or beriberi, or can increase susceptibility to infection and illness. Good eating habits established early in life help to produce a healthy person who will reduce the requirement for medical or dental care. A society which stresses proper nutrition, and which ensures that its populace has access to adequate food, should be able to decrease its overall expenditures in the health field.

The dietitian or nutritionist, who specializes in the study of nutrition for both healthy and ill persons, must therefore be considered, at least in part, a member of the healing arts. Her primary function in this area is therapeutic nutrition, including the development of menus to meet the needs of persons requiring special diets as a result of illness, allergies, or other limitations. She also offers assistance to the public, either through the mass media or on an individual basis, on good dietary habits. She works closely with other members of the healing arts, particularly with physicians and dentists, in providing special diets and developing educational material. In other capacities she may be employed by industry or government for positions in food services administration, customer education or personnel training. In the hospital she is responsible for food services administration, as well as for teaching and research.

Manpower

In 1969 the Ontario Dietetic Association reported 428 registered professional dietitians in Ontario,¹ all of whom must have met the requirements of the Association for registration as a professional dietitian. These requirements include completion of a Bachelor's degree in foods and nutrition from an accredited

¹See Chapter 6, p. 191.

university, and one of the following: 1) a dietetic internship; 2) three years' diversified experience; 3) a Master's degree plus one year's experience; 4) two year's experience in teaching as a full-time member of a university or college staff. Of these dietitians, in 1967, 41.6 per cent were employed in hospitals, 10.2 per cent in government departments, and 12.8 in universities and schools. The remainder were employed primarily by business and industry, or were not working in dietetics.

In 1967 the Ontario Hospital Services Commission (OHSC) reported 348 dietitians employed full time in hospitals in Ontario, and another thirty-seven part time. The definition of dietitian used by the OHSC includes many who are not registered with the Association, and who therefore may not be qualified dietitians.

Education

There are four universities in Ontario offering degree programs in food and nutrition. These are the universities of Toronto, Guelph, Western Ontario and Ottawa.

The programs at Toronto, Guelph and Ottawa are of four years' duration after grade thirteen, while the one at Western is three years. All lead to a Bachelor's degree. A Master's program is offered at Toronto and Guelph.

An internship, which is not part of the requirement for a degree, is necessary for those who wish to obtain registration from the Ontario Dietetic Association. The internship may be taken either as an integrated program, in which the first two phases of a total of fifteen weeks are taken during the final two summers of the academic program, and the final phase of twenty weeks after graduation; or as a postgraduate internship of one year following graduation. Eight hospital programs in Ontario are accredited by the Canadian Dietetic Association to offer the integrated internship, and four for the postgraduate internship.

Regulation

There is no provincial regulation of dietitians in Ontario. As mentioned above, the Ontario Dietetic Association, a voluntary association, grants the title "Registered Professional Dietitian" to those meeting its requirements for registration outlined above. This designation is granted under the authority of the Ontario Dietetic Association Act, a private act, passed in 1958.²

This Committee does not believe there is a need for any regulatory measures at this time.

Relationship with Other Groups

The main areas of concern of the groups representing dietitians who appeared before the Committee were the lack of understanding by other members of the

²S.O. 1958, c. 147

healing arts of the contribution that therapeutic nutrition can make to the patient's recovery and well-being, and the need for increased nutrition counselling beyond the hospital setting.³

It was suggested to us by representatives of the Faculty of Food Sciences, University of Toronto, that a course in basic nutrition under the direction of a qualified nutritionist should be offered in the faculties of medicine, dentistry, nursing and education, in order to create a better understanding by these professions of the value of nutrition.⁴ While more pressing priorities in the already crowded curriculum in these disciplines may make such a suggestion unfeasible, we agree that efforts should be made towards increased interdisciplinary understanding, and that encouragement should be given to hospitals to employ trained dietitians and to utilize their special abilities in teaching and therapeutic nutrition.

Supplementary Personnel

Personnel supplementary to registered dietitians are generally known as food supervisors. The Ontario Hospital Association conducts a six-month in-service training program in Toronto and a correspondence course, both designed for food supervisors intending to work in a hospital setting. There are no specific educational prerequisites for these programs. High school programs at Beale High School in London and at Central Technical School in Toronto train students for food supervisory positions concurrently with completion of the secondary school diploma. A night school program for food supervisors also is available in London and Toronto under the auspices of the Boards of Education. Many hospitals and places of business which are unable to acquire trained food supervisors conduct their own unstructured in-service programs. A more extensive program is the three-year course offered at Ryerson Polytechnical Institute where, after a common two-year home economics food administration course, students may select a third year option in food administration; this may lead to such positions as a dietary assistant in a hospital, or a food technologist.

These programs train food supervisors to undertake the more routine tasks of a dietitian but do not qualify them to plan medical diets.

Medical Record Personnel

Medical records have been kept for many years by physicians and by hospitals in forms varying from the cursory to the complex. In this chapter our concern lies predominantly with medical records in hospitals, although we do comment on other medical records as well. With the growth of hospital care and of the size of hospitals, the maintenance of accurate and complete patient records became increasingly important.

³Ontario Dietetic Association, Brief to the Committee on the Healing Arts, 1967, pp. 9-10.

⁴University of Toronto, Faculty of Food Sciences, Brief to the Committee on the Healing Arts, 1966, p. 2.

Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care; they provide a means of communication between the physician and other professional groups contributing to the patient's care; they furnish documentary evidence of the course of the patient's illness and they serve as a basis for review, study and evaluation of the medical care rendered to the patient.⁵

The responsibility for the care of these records rests with the medical records department of the hospital. This department is often under the supervision of a trained medical record librarian; in some hospitals, however, clerical staff, who may not have received formal training beyond that received on the job are in charge of the medical records department.

The basic duties of medical record personnel are to assure that adequate patient records are maintained and filed. These records include information on the diagnosis, treatment, test results, and the continuing progress of the patient.

A prime purpose of the medical records is, of course, to provide the physicians and hospital staff with as complete information as possible for the care of the patient. In addition, the records may be used by the Medical Review Committee and the Medical Audit Committee in the hospital to ensure that appropriate standards are being maintained in the hospital, and to review frequency of surgical procedures and the patterns of treatment being undertaken by individual physicians. Further, the correlation of information from these records is often of assistance in research studies within the hospital or between hospitals. Finally, the records are most valuable in the teaching of health personnel where they will be used in the presentation of a case study to be analyzed by students.

The failure of a physician to keep adequate medical records of his patients is usually a matter for disciplinary action within the hospital, and in some cases it is the responsibility of the medical record librarian to draw to the attention of the appropriate authorities, records that are incomplete.⁶

The Medical Record Librarian

The complexity of the duties of the medical record librarian varies with the size and status of the hospital in which she works; for example, the medical record librarian in a large teaching hospital would be called upon to assist the medical staff in research projects more frequently than would the medical record librarian in a smaller hospital. There are, however, certain duties which are basic to the efficient running of a medical records department: for example, reviewing the records of patients to ensure that the standards of the Canadian Commission on Hospital Accreditation are met; coding and indexing disease conditions, operations

⁵Bulletin No. 10, December 1955, of the Joint Commission on Accreditation of Hospitals, quoted in Accreditation Creed No. 1, Canadian Council on Hospital Accreditation, January 1960, p. 10.

⁶Ontario Association of Medical Record Librarians, Transcript of the Hearings of the Committee on the Healing Arts, June 13, 1967, p. 4266.

and special treatments; assisting the medical staff in research; preparing statistical and narrative reports on the utilization of the hospital or clinic, and serving on the hospital's Medical Records Committee.

In 1963 the Ontario Hospital Medical Records Institute (HMRI) was established through the joint efforts of the Ontario Hospital Association, the Ontario Medical Association and the Ontario Association of Medical Record Librarians, all of which are partners in the Institute and are represented on its governing board. The Institute operates a data processing service to produce indexes and analyses of medical records, and this has simplified the coding duties of those medical record librarians who work in hospitals belonging to the Institute, which support the Institute by the payment of fees for these services. The librarian abstracts certain information from the patient's record and transfers it to a form provided by the Institute. At this Institute, the data are classified by categories, such as diagnosis, operative procedures, length of stay, physician. These indexes then become available to the individual hospitals for administrative and research purposes.

Supply

As there is no comprehensive register of medical record librarians, it is difficult to obtain complete manpower figures. The Canadian Association of Medical Record Librarians (CAMRL) has developed a certification program; and only medical record librarians who have been trained at a school approved by CAMRL and who have passed the Association's registration examination are permitted to designate themselves "Registered Record Librarian" (R.R.L.). The Association also certifies medical record technicians and clerks who have completed approved programs.

In 1969 CAMRL estimated that there were 329 registered record librarians, forty-two accredited record technicians, and 110 students or unregistered graduates of approved courses in medical records actively employed in Ontario.⁷

Certain factors operate to encourage the employment of registered record librarians or other personnel who have received formal training in the techniques of handling medical records in hospitals. The hospital accreditation standards established by the Canadian Council on Hospital Accreditation require that in the Medical Records Department there should be "qualified personnel adequate to supervise and do the work of the department".⁸ While this requirement is interpreted with sufficient flexibility to permit a smaller hospital to have an accredited record technician in charge of the department and even a trained medical record clerk in the case of hospitals with under fifty beds,⁹ there must, in such cases, be consultant librarian services available.

⁷Communication received by the Committee on the Healing Arts from CAMRL, May 1969.

⁸Standards for the Accreditation of Ontario Hospitals, Second Edition, 1963, p. 4.

⁹Ontario Association of Medical Record Librarians, Transcript of the Hearings of the Committee on the Healing Arts, June 13, 1967, p. 4290.

Most medical record librarians are employed in hospitals. In Ontario in 1968 there were 295 full-time and twenty-seven part-time medical record librarians employed in 203 public general hospitals,¹⁰ though these numbers include some unregistered librarians. Not all hospitals employ a registered record librarian, and many of the larger hospitals employ more than one. The nineteen teaching hospitals, for example, employed ninety full-time medical record librarians in 1968, while in the same year only sixty full-time medical record librarians were employed by the ninety-three public general hospitals with bed capacities of less than 100.¹¹

While the largest demand for such personnel is from hospitals, other agencies also employ them. OHSC employs two librarians who provide advisory services to record personnel in hospitals throughout Ontario. HMRI also employs two librarians, and one librarian works with a St. Catharines group practice clinic.

Education

Medical Record Librarians

Three hospitals in Ontario operate schools for medical record librarians approved by the Canadian Association of Medical Record Librarians: Hôtel Dieu, Kingston; St. Michael's Hospital, Toronto; and Ottawa General Hospital, Ottawa. The Ontario Association of Medical Record Librarians lists the student capacities of these schools as, respectively, six, thirty-two, and eight; but the St. Michael's school, which has been operating since 1936, usually limits its enrolment to approximately one-half of its capacity because of the restrictions of budget, staff and facilities. The three hospital schools have graduated a total of 377 students since their inception up to and including 1967.¹²

All the schools approved by CAMRL have met the Association's standards and have been inspected by a team from the Association. The standards cover administration and organization, facilities, faculty and curriculum. They are reviewed once a year at a joint meeting of the directors of the medical record librarian schools and the Canadian Association of Medical Record Librarians.

The educational prerequisites for the medical record librarian schools are senior matriculation, a nursing diploma from an accredited nursing school, or an elementary school teaching certificate. As well, the applicant must be proficient in typing.

In 1965 the Directors of the medical record librarian schools and the Board of Registration of CAMRL recommended that the educational prerequisite for entry into the schools should be a baccalaureate degree. While the recommendation was accepted by the Executive Committee of CAMRL and was to go

¹⁰OHSC, *Annual Report (Statistical Supplement)*, 1968.

¹¹*Ibid.*

¹²Ontario Association of Medical Record Librarians, *Brief to the Committee on the Healing Arts*, 1966, p. 5.

into effect in 1968, a majority of the membership opposed the change at the annual meeting of the Association; the proposal was rescinded and is being held in abeyance.¹³

The programs offered in Ontario last twelve months, and include both theory and practical work. The students study medical record science, anatomy, physiology, medical terminology, psychology, and medical essentials; and participate in the work of the hospital medical records department. An affiliation program between St. Michael's Hospital and ten accredited hospitals in the Toronto area was inaugurated in 1968, permitting students at the St. Michael's School to gain practical experience in other hospitals.

From 1955 to 1963 a two-year extension course for Medical Record Librarians was conducted under the joint sponsorship of CAMRL and the Canadian Hospital Association. Graduates of this course were permitted to write CAMRL registration examinations provided that they had the educational prerequisites required of students in the regular medical record librarian schools.

There are two university programs at present for medical record librarians. One at the University of Nelson, British Columbia, is four years and leads to a Bachelor's degree in record library science. The other university program commenced in 1969 at the University of Sherbrooke, the first such course to be offered at a university with a medical school.

The Committee does not believe that an increase is necessary in the educational requirements for entrance to training as a medical record librarian; it would not be appropriate to require an undergraduate degree for entry to this field.

Medical Record Technicians and Clerks

In 1962 an extension course for training medical record personnel other than librarians was instituted under the sponsorship of the Canadian Hospital Association, in cooperation with CAMRL. All applicants must have six months' experience in a hospital medical records department; be proficient in typing; and be recommended by the hospital administration, who must also supply the name of a physician on staff who will assist the student with problems in anatomy and terminology. The academic requirement for clerks is completion of at least two years of a four-year high school program; for technicians, junior matriculation or graduation from a nursing school is required.

The course is divided into two parts. The students first complete an eight-month home study course, followed by a three-week intramural session. Students are examined after the home study section of the course, and those obtaining a minimum of 50 per cent receive a certificate as "medical record clerks". Those who obtain a minimum of 60 per cent and who have the necessary educational

¹³Ontario Association of Medical Record Librarians, Transcript of the Hearings of the Committee on the Healing Arts, June 13, 1967, p. 4279.

prerequisite may proceed with the second section of the course—three weeks of practical experience in the medical records department of a hospital selected by the extension course supervisor for the purpose. Satisfactory completion of the entire program qualifies the student to write examinations set by CAMRL leading to the title “Accredited Record Technician” (A.R.T.).

A one academic year program to train medical record technicians is being introduced at Fanshawe College of Applied Arts and Technology in London. The entrance requirement is grade twelve, and courses include medical terminology, anatomy, physiology, microbiology, medical essentials, medical record sciences, computer sciences, secretarial practice, English and Human Relations. The students also take four weeks’ practical experience in a hospital at the end of the academic program.¹⁴ This program has been approved both by CAMRL and by the Ontario Association of Medical Record Librarians, and graduates will be eligible to write the examinations leading to A.R.T. certification. CAMRL stipulates, however, that its approval is given only upon the understanding that the students have the educational prerequisites established by CAMRL for the A.R.T. The curriculum is subject to the approval of CAMRL’s Committee on Education and Registration; the person in charge of the course is an R.R.L. in good standing in CAMRL, and is approved by the Committee on Education and Registration; and the course is subject to inspection as required by CAMRL.¹⁵

A course for medical record technicians commenced in 1968 at the Niagara College of Applied Arts and Technology. This program was not established in accordance with the requirements of CAMRL, however, and thus is not approved by the Association.¹⁶ It is a two-year program and, as indicated in Table 6.54 in Chapter 6, there were twenty-seven enrolled in the program in 1968-1969, with an expected enrolment of fifty-seven and twenty-three graduates in 1969-1970.

Future Developments

The Committee believes that the three hospital schools have provided good training for medical record librarians. However, the present system of education has placed a burden on the staff and facilities of the three hospitals involved, and there has not always been adequate financing of these programs. We do not believe that the introduction of university level programs for medical record librarians would be an appropriate allocation of resources at this time. We are encouraged, however, by the introduction of such programs in Colleges of Applied Arts and Technology, and we recommend further developments of this kind. We believe that the location of educational programs for medical record librarians should be reviewed by the Department of Health and the Ontario Council of Health, and that transfers to

¹⁴*Medical Record Technician, 1969-1970*, Fanshawe College of Applied Arts and Technology, London, Ontario (course bulletin).

¹⁵Communication received by the Committee on the Healing Arts from CAMRL, May 1969.

¹⁶*Ibid.*

Colleges of Applied Arts and Technology should be made as soon as suitable courses can be instituted and arrangements made with local hospitals for a period of practical experience in the medical records department of a hospital.

The principles we outline in Chapter 26 regarding the education of health practitioners should also apply to the education of medical record librarians and other medical record personnel. In particular we believe that the control of educational programs for medical record librarians and medical record technicians should be within the Department of Education. For reasons given in Chapter 26, we believe that it is not appropriate for education to be under the control of either a voluntary association or a regulatory body.

Recommendation:

- 246** That the Department of Education be responsible for the education of medical record personnel and that educational programs for medical record personnel be transferred to Colleges of Applied Arts and Technology where feasible. An Educational Advisory Committee for medical record personnel should be established to advise the Minister of Education on proposed educational programs for medical record personnel, and on the length and content of such programs, and to accredit all educational programs for medical record personnel.

Regulation

While CAMRL certifies medical record personnel, it cannot strictly be called a "regulatory body", since, as we have explained, registration is not mandatory and the Association is private, not subject to review by the Department of Health. The national organization, which was formed in 1942 and received a national Charter in 1949, grew out of an Ontario Association formed in 1935. The Ontario Association of Medical Record Librarians became a provincial branch of CAMRL in 1950.

As we have already outlined, CAMRL establishes standards and inspects schools for medical record librarians. The Association also holds certification examinations for medical record technicians who have completed both stages of approved courses. Before writing the CAMRL examination, both librarians and technicians must first be members of a provincial branch of the Association, and then of the Canadian Association. Once certification is received, there is no obligation to maintain membership in the Association.

While the Canadian Association still has sole jurisdiction over education, the Ontario branch has an education committee which makes recommendations to the Canadian Association. The provincial branch advises CAMRL whether new courses in Ontario meet the approved criteria.

And with health technologists, we do not believe that medical record personnel should be given the right to self-government or should be required to obtain a

licence to practise. Medical record personnel should be certified by the Health Disciplines Regulation Board through an appropriate Medical Record Personnel Division. Registration by CAMRL could also continue, and would increase the mobility of medical record personnel trained in Ontario.

Recommendation:

- 247** That medical record personnel be certified by the Health Disciplines Regulation Board, through a Division for Medical Record Personnel, and that various levels of certification be developed as required to differentiate between librarians, technicians and clerks.

Chapter 18 Health Technologists

This chapter deals with five groups of health technologists: medical laboratory technologists, radiological technicians, electroencephalograph technicians, inhalation therapy technicians and medical electronics technicians. While this is by no means an exhaustive list, these groups provide a sufficiently broad sample of occupations to be adequate for the purposes of our study.

The rapid development of medical technology during this century has made and continues to make available to the physician increasingly sophisticated diagnostic and therapeutic aids in the form of mechanical and electronic equipment and technical procedures. In the process it has given birth to a number of specialized “auxiliary” occupations involving the operation and maintenance of this equipment and the performance of these procedures.

The development of the health technologists’ occupation reflects the progressive refinement and specialization of technology. To provide a precise “job description” of any particular health technology occupation is difficult; the content of the occupation changes as technology changes and as new specialties continually arise. These specialties may be generated as subdivisions of recognized occupations, such as medical laboratory technology and radiological technology, or as responses to technological developments in other fields, such as inhalation therapy or medical electronics technology. It is in the larger hospitals, with their more elaborate equipment and greater incidence of specialized cases, that this occupational differentiation first occurs, and it is here that highly specialized technologists function. In small hospitals and private laboratories, which usually refer cases requiring specialized competence to larger hospitals, the nature of the case load and the available equipment usually require more general skills on the part of the technologist.

The “vertical” division of skills among health technologists — that is, the differentiation by *type* of skill — is the most obvious form of differentiation within this group. There is also, however, a “horizontal” distinction between *levels* or *degrees* of skill required in the performance of functions in the field of health technology. This latter type of differentiation has received less recognition in educational and regulatory provisions.

Role

Although there are certain diversities of organization, mobility and supervision among the health technologist groups, two general similarities may be noted. In the first place, with very few exceptions health technologists work in a hospital

setting. The exceptions are those laboratory technologists and x-ray technicians who work in private laboratories and clinics, and the small proportion (five out of eighty-four in Ontario in 1968) of electroencephalograph technicians in Ontario who work outside hospitals.

The second common characteristic of all health technologists is their subordinate, rather than initiatory, role. The health technologist exercises no discretion in the choices of the tests performed or the treatment administered; the decisions are made by a physician and the health technologist follows instructions. In some cases the health technologist works in continuous interaction with a wide assortment of related workers. In others, the work is carried on in relative isolation. But always the ultimate responsibility for the work lies, not with the technologist, but with medical or administrative personnel.

Oswald Hall, in his study of paramedical personnel in selected hospitals in Ontario conducted for this Committee, has described in considerable detail the functions of various groups of health technologists. The reader is referred to this study, published separately,¹ for a fuller discussion of the role of these groups in the hospital. In what follows we shall attempt only a brief characterization of the range of functions involved in several areas of health technology.

Medical Laboratory Technologists

Medical laboratory technologists are the largest and fastest growing group among the paramedical occupations. The accelerating pace of advance in medical science has led to a great increase in the range of sophistication of laboratory testing, and has resulted in a concomitant specialization within the group of laboratory technologists. Basically, medical laboratory technologists carry out tests on specimens of body tissue and fluid for diagnostic purposes. The hospital medical laboratory began as a small service unit with generalist technicians performing a limited range of tests, and in smaller hospitals this situation still exists. During the past two decades the larger hospitals have expanded their laboratory facilities, so that each of the different types of testing—pathology, haematology, biochemistry, blood bank and bacteriology—is conducted in a separate laboratory, and the laboratory technologist specializes in one of these fields. Specialization may be carried to the extent that one technologist performs only one task within a specialized field.

A brief description of each of these fields will indicate the range of functions performed by laboratory technologists. In the bacteriology laboratory, the technologist investigates the presence, character and effects of living organisms, bacteria, fungi and parasites within the body by examining cultures grown from specimens taken from the patient. In the biochemistry laboratory, the technologist performs chemical analyses on specimens, either by hand or by machinery. In

¹Oswald Hall, *The Paramedical Occupations in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970.

the blood bank, the technologist determines the exact blood type of a patient, and cross-matches it with donor blood. In the haematology laboratory the technologist counts and identifies the cells in a blood sample; and in the pathology laboratory, which is further divided into cytology and histology sections, the technologist prepares slides of tissue specimens for examination by the pathologist, and examines tumors and other body materials for the presence or observation of malignant cells.

Although their work is part of the overall effort in the diagnosis and treatment of disease, technologists have limited contact with patients. They work on their own in the laboratory, supervised by a chief technologist and by the medical director of the laboratory.

Radiological Technicians

Depending on the size of the radiology department, the radiological technician may work in one of three areas of medical service in which ionizing radiations are administered to patients. In diagnostic radiology, by far the largest area of practice, upon the prescription of a physician and under general medical supervision, the technician produces x-ray photographs for the diagnosis of injury or disease. In radiotherapy, on the instructions of a physician, the technician administers ionizing radiations to the patient for the treatment of disease; and in nuclear medicine, the technician assists a specially trained physician in administering radioactive isotopes to a patient for both diagnostic and therapeutic purposes. The technician does not interpret x-rays, or determine the prescribed dosage of radiation; those functions are performed by the radiologist.

Because radiation can be harmful to both the patient and the technician unless correctly administered, the technician must exercise care in positioning the patient and operating the equipment. In the larger hospitals, technicians may specialize in one field of radiology, such as cardiovascular work, or fluoroscopy.

A radiological technician who works in a private laboratory or clinic will be primarily involved in diagnostic radiology; and, like the technician in a smaller hospital, will probably have little chance to specialize in any specific field of radiology.

Inhalation Therapy Technicians

This occupation is a very new one, and as yet only large hospitals have separate inhalation therapy departments. In many hospitals, most of the functions performed by an inhalation therapy technician are carried out by "oxygen orderlies" and nurses.

The inhalation therapy technician administers treatments and checks, repairs and delivers equipment. The treatments are called intermittent positive pressure breathing, a new form of therapy for pulmonary patients. The patient breathes a gaseous mixture in a certain rhythm from a "respiration" machine. The treat-

ment usually lasts fifteen minutes, four times a day. The inhalation therapy technician also checks daily the inhalation equipment in use in the wards, such as oxygen equipment and humidifiers; repairs faulty equipment and cleans each piece of equipment before it is used by another patient; and delivers the required equipment to the floor. These calls for equipment may be emergencies, as in the case of cardiac arrests. The tasks of maintenance, repair and delivery of equipment, which constitute the "core" functions of these personnel, require relatively modest levels of skill and, as noted, have traditionally been performed by oxygen orderlies and nurses.² It is the issue of the role of the inhalation therapy technician in *treatment* which has formed "the main wedge used by the inhalation therapy technicians in their drive for status".³ Although in Canada the nature and extent of the contact of the inhalation therapy technician with the patient varies widely among hospitals, Hall reports that in one Canadian hospital included in his survey, such personnel "mix the chemicals, administer the treatments, and even have the doctor's prescriptions countermanded if they seem incorrect". In the United States, treatment "is the main function of the more professionalized inhalation therapy technicians".⁴

Electroencephalograph Technicians

The electroencephalograph technician runs an instrument that records electric currents developed in the brain by means of electrodes applied to the scalp or to the surface of the brain, or placed within the substance of the brain during the E.E.G. test. Throughout the test the technician observes the patient's behaviour and makes appropriate notes on the recording graph. He then analyzes the finished recordings for possible false readings. The physician (usually a neurologist, neurosurgeon or neuropsychiatrist) who specializes in electroencephalography uses the electroencephalograph tracings in diagnosing brain disorders. The technician must be able to recognize abnormal wave patterns indicating physical changes in the patient. To know whether the instrument is functioning properly, he must be thoroughly familiar with his equipment and he is in general responsible for making minor adjustments and repairs. The technician must also be skilful in handling patients, for the E.E.G. test can take over an hour to carry out and the patient must be calm during the examination.

Electrocardiography Technicians

The electrocardiography (E.C.G.) technician works with a compact machine, often portable, which records the activity of the heart. The tracings produced are used by physicians in the diagnosis and treatment of heart disease.

The largest number of E.C.G. technicians are employed in hospitals, although

²*Ibid.*, pp. 58-59.

³*Ibid.*, p. 59.

⁴*Ibid.*

large group practices and health clinics may purchase electrocardiogram equipment and employ their own technicians in order that their patients do not have to go to a hospital to have this test done. A few private laboratories also provide such a service.

The request for a test is initiated by a physician; and in hospitals, the E.C.G. technician may take a portable machine to the ward, or the patient may be brought to the area where the E.C.G. technician operates the equipment. The time required to take an electrocardiogram is short — four to ten minutes per patient. After the test the technician cuts and mounts the tracing which is then sent to the physician for interpretation.

There are no accurate data on the number of E.C.G. technicians in Ontario. The reports of the Ontario Hospital Services Commission do not list E.C.G. technicians in a separate category, and in some hospitals the electrocardiogram machines may be operated by a laboratory technician or a nurse.

As the work of these technicians requires a minimum of medical background and can be learned on the job in no more than two months of observation and practice, no formal training programs have been established. We do not foresee the immediate need for such programs.

There is no association representing E.C.G. technicians, and we did not receive any submissions on their behalf. Hall, however, reported that there did not appear to be any problems in recruiting E.C.G. technicians, as this is an occupation which often appeals to former nurses who are willing to take a lower salary in return for reasonable working hours and a job which appears to be less demanding, both mentally and physically.⁵

Medical Electronics Technicians

Medical electronics technicians, probably the newest and smallest of the paramedical groups, are employed by hospitals to operate, test and repair modern electronic equipment such as catheters, electroencephalograph machines, heart-sound equipment, and the equipment in the intensive care and coronary sections. As more electronic equipment is used for diagnosis, patient monitoring and operating room procedures, hospitals require technicians with mechanical skills and theoretical knowledge. In some hospitals medical electronics technicians design new combinations of equipment, and take part in such medical procedures as catheterization, in special units known as cardio-catheterization laboratories. In preparation for these procedures, the technician constructs tubes and catheters to fit the individual patient, calibrates the equipment and monitors it during the operation, and transfers the recordings to paper after the operation. A fairly high level of skill and competence is required and exhibited by these technicians in the performance of their functions.⁶

⁵*Ibid.*, pp. 92-95.

⁶*Ibid.*, pp. 53-54.

Manpower

Because there are no registration or licensing requirements for the health technologist occupations, it is difficult to obtain detailed manpower figures for these groups. In the case of some of the newer occupations, there is the added difficulty of definition, for recognition of an occupation as a separate entity may take a number of years. For example, the Ontario Hospital Services Commission (OHSC) lists only the following categories under technicians: laboratory, radiological, and combined laboratory and radiological. Table 18.1 shows this distribution for the period 1960 to 1968.

TABLE 18.1

Medical Technicians Employed in Public General Hospitals, Ontario, 1960-1968¹

Year	Laboratory technologists		Combined radiological and laboratory technologists		Radiological technicians	
	Full time	Part time	Full time	Part time	Full time	Part time
1960	1,234	94	—	—	808	32
1961	1,478	112	11	1	921	38
1962	1,561	123	11	—	887	51
1963	1,449	145	65	1	701	52
1964	1,516	146	44	6	752	54
1965	1,769	201	21	—	849	69
1966	2,013	197	9	—	960	78
1967	2,436	252	7	—	1,048	94
1968	2,777	275	7	—	1,148	87

¹Numbers include personnel not registered with the Canadian Society of Laboratory Technologists or the Canadian Society of Radiological Technicians.

SOURCE: Ontario Hospital Services Commission, *Annual Report (Statistical Supplement)*, 1960 to 1968.

It is not certain how many medical laboratory technologists and radiological technicians work outside the hospital setting. The study of private clinical laboratories prepared for the Committee found that there were 365 medical laboratory technologists working in these private laboratories, of whom 59 per cent were registered with the Canadian Society of Laboratory Technologists.⁷ In 1968, the Canadian Society of Laboratory Technologists had 1,507 members in Ontario with general subject registration, 198 members holding advanced registration,

⁷CERCL, *Private Clinical Laboratories in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, p. 19.

and forty-seven with a higher level of advanced registration, the licentiate. Of the 815 associate members, 364 were non-certified and 450 were undergoing training.⁸

The Board of Radiological Technicians of Ontario, to be described below (p. 430), maintains a Register of those radiological technicians who have met its standard for registration.⁹ However, since such registration is not necessary for practice in Ontario, the Register cannot be considered to include all practising radiological technicians in the province. Tables 18.2 and 18.3 show the registrations with the Board from 1967 to 1969 and the membership in the Ontario Society of Radiological Technicians for the same period.

TABLE 18.2
Registrations under the Radiological Technicians Act, 1967-1969

Year	New registrations	Total registrations
1967	377	1,632
1968	303	1,935
1969 ¹	120	2,055

¹To April 30, 1969.

SOURCE: Board of Radiological Technicians, Ontario, letter to the Committee on the Healing Arts, May 16, 1969.

TABLE 18.3
Membership in the Ontario Society of Radiological Technicians, 1967-1969

Membership	1967	1968	1969
Active	914	1,029	1,110
Non-practising	168	151	168
Active O.S.R.T. (formerly associate)	82	105	100
Commercial associate	9	7	9
Radiologists	1	3	4
Students	529	520	574
Arrears	201	282	306

SOURCE: Ontario Society of Radiological Technicians, letter to the Committee on the Healing Arts, May 16, 1969.

⁸Canadian Society of Laboratory Technologists, *Bulletin*, May 1969.

⁹In effect, then, the Board is a "certifying" body.

The two outstanding features of the medical laboratory technologist and radiological technician groups from a manpower perspective are the high attrition rate and the high percentage of females. The two features are interrelated; for many women, health technologist jobs are a prelude to marriage and they may remain in the field for only one to three years. The entry of men into the field is discouraged both by the level of salaries, which, while adequate for single women, is low for a man supporting a family, and by the paucity of opportunities for advancement. Hall discovered that 84 per cent of the medical laboratory technologists in the hospitals he visited were female.¹⁰ The Ontario Society of Radiological Technicians in its brief to the Committee pointed out that in 1966, only 21 per cent of the Society's members were male, and only 8 per cent of the student members were male.¹¹

Hall's study also indicated a heavy reliance by the hospitals on foreign-trained medical laboratory technologists. In the hospitals covered by his study 43 per cent of the technologists were born and trained outside Canada; 12.9 per cent of all the technologists were from Eastern Europe; 11.4 per cent from the United Kingdom, and 9.1 per cent from the Philippines.¹²

The evidence indicates that increased numbers of health technologists in all fields will be required in the coming years, though we have not attempted to quantify the exact requirements for each group. While automated equipment to some extent may reduce the number of technologists required, the increased demand for tests would cause an off-setting increase in the volume of work. In 1966 the OHSC prepared a study on the projected need for laboratory technologists until 1970. Given an average annual increase in the number of units of laboratory work per patient of 12.25 per cent, from 1961-1964, it was estimated that 3,520 technologists would have to be trained between 1964 and 1970 to handle the projected work load.¹³

The Committee believes that this type of research should be carried out for all health technologist groups, and the findings utilized in planning educational programs. Such studies should devote considerable attention to the possibilities of horizontal division of functions as mentioned at the outset of this chapter. It may be that the most rational educational system for health technologists is one comprising programs of varying lengths as well as varying content, aimed at the production of groups of personnel competent to perform functions demanding varying levels of skill. Opportunities should exist, of course, for personnel trained at one level to advance to further training.

¹⁰Oswald Hall, *op. cit.*, p. 41.

¹¹The Ontario Society of Radiological Technicians, Brief to the Committee on the Healing Arts, 1966, p. 10.

¹²Oswald Hall, *op. cit.*, p. 41.

¹³*Projected Need for Laboratory Technicians*, Report by Miss Naomi Grigg, Director, Statistical Research, Ontario Hospital Services Commission, June 1966.

Recommendations:

- 248** That the Department of Health and the Ontario Council of Health keep a close watch on the requirements for all types of health technologists and undertake long-range planning in order to anticipate the needs in Ontario for such personnel. At the same time the Council should undertake continuing research to determine the need and role for new kinds of health technologists and to make provision for the education and regulation of such groups as they develop.
- 249** That the Research and Planning Branch of the Department of Health in conjunction with the Research Unit of the Ontario Hospital Services Commission undertake studies on the utilization and role of health technologists in both hospital and private settings. Such studies should include a review of working conditions for these groups and attempts should be made to encourage employers to improve working conditions in order to attract greater numbers into these occupations.

A potential source of manpower in health technology that will grow over time lies in the group of trained but "inactive" technologists who have left the field. We have indicated elsewhere in this chapter (see p. 429) that we consider the provision of refresher courses to constitute one approach to the tapping of this pool. Since many of these inactive technologists are women who retired from employment to marry, however, the main obstacle to recruitment is the lack of employment opportunities compatible with the demands of their roles as wives and mothers.

Recommendation:

- 250** That efforts be made by the Department of Health and the voluntary associations to attract into employment some of the qualified technologists not presently employed; and that employers review their employment needs in order that, where possible, part-time employment opportunities may be developed for health technologists.

Finally, any attempt to increase recruitment into this field must consider the provision of realistic and attractive levels of salary. Salary scales have not offered to medical technologists performing more highly skilled functions the remuneration warranted by their training and competence.¹⁴ Any change in salaries to rectify this situation, however, must occur together with attempts to ensure a rational and effective utilization of skills on all levels.

¹⁴Oswald Hall, *op. cit.*, pp. 46-48.

Recommendation:

- 251** That a continuous review of salaries of health technologists be made by the Department of Health and the Ontario Council of Health, and that where unattractive salaries have been the main factor in depressing the numbers entering these occupations, appropriate steps be taken to increase salary levels.

Education

Control of Education

Until the late 1950's, the education of health technologists in Ontario was conducted primarily through a system of apprenticeship. Prospective students would apply directly to a hospital where they would be trained on the job under the supervision of more experienced technologists. As the need arose, some hospitals began to develop didactic programs for apprentices, particularly in medical laboratory technology and radiological technology. Since 1967, some training programs for these two occupations have been established in Colleges of Applied Arts and Technology.¹⁵

The training of laboratory technologists initially ranged from six to twelve months. Since 1960, it has increased from twelve to between twenty-one and twenty-four months in most cases. This period includes a formal lecture program of one year followed by an internship year. In 1967, twenty-five hospital schools were operating with a total enrolment of 550 students in both years of the program, of whom 260 graduated.

In recent years, centralized institutes have developed for the teaching of medical laboratory technology under the auspices of the OHSC. The Toronto General Hospital initiated the first central school when it established a Technician Training School in 1959 for its own students and in 1963 established a central school for thirteen hospitals in the surrounding city area. In 1966, the Toronto Institute for Training in the Technological Aspects of Medicine was established. Its purpose is the establishment of a large training centre for medical laboratory technologists near the cluster of hospitals in central Metropolitan Toronto. In 1961 a regional school of medical laboratory technology was founded by joint agreement between four hospitals in the London-St. Thomas area, and was transferred to the jurisdiction of the OHSC in 1966. The Hamilton Health Association initiated a training program through the Hamilton and District School of Medical Technology in 1962 to serve fifteen affiliated hospitals in that area. The first year of the program is given in the central school, and the second is a year of practical experience taken in an affiliated hospital. By 1967 these three central schools had thirty-three hospitals affiliated with them and an enrolment of 319 students.

¹⁵Algonquin, Lambton and Cambrian Colleges offer courses in laboratory technology; Confederation and Fanshawe Colleges offer courses to train radiological technicians.

The hospital schools and the central schools have all been approved by the Canadian Medical Association Committee on approval of Training Programs for Laboratory Technologists.

The first school of medical laboratory technology to be introduced under the financing and authority of the Department of Education was established in 1967 at the Algonquin College of Applied Arts and Technology in Ottawa. On completion of the formal six-semester training program offered by Algonquin College over two and a half calendar years, the student requires a further ten months of internship at an approved affiliated hospital before being eligible for certification with the Canadian Society of Laboratory Technologists. Both the formal and internship part of the program must be accredited by the Canadian Medical Association Committee on Approval of Training Programs in Medical Laboratory Technology before the graduates are eligible to write certification examinations.

The students in laboratory technology at hospital or regional schools pay no tuition fees and are eligible for a living allowance of \$140 per month provided by the OHSC. They are eligible for the OHSC allowance only if they are sponsored by a hospital, with such an allowance being given during the final four semesters of the program. The allowances are channelled through the sponsoring hospital, and the College is not involved in the administration of these allowances. Students at Algonquin pay tuition fees of \$75 per semester.

Three more programs for medical laboratory technologists began in the autumn of 1969. At Lambton College in Sarnia, a one-year program open to grade twelve students will permit graduates to continue into the two-year program at the School of Technology at Sarnia General Hospital. The hospital school presently requires grade thirteen standing for admission. At the North Bay campus of Cambrian College, a three-year biological sciences technology program is offered, and graduates who complete a further ten months of practical training in a hospital are eligible to write the Canadian Society of Laboratory Technologists registration examination. A program at St. Clair College in Windsor, being given in cooperation with area pathologists, follows the pattern established by Algonquin College. Niagara College in Welland and the South Porcupine campus of Northern College also have indicated that they are planning programs in medical laboratory technology.¹⁶

The training of radiological technicians takes place primarily in sixty-four separate hospital schools offering a two-year course, with one year of didactic training and one year of practical experience. In 1958 through the efforts of the Canadian Society of Radiological Technicians, formal standards were established for the training of radiological technicians. Training schools are now accredited by the Canadian Medical Association Committee on Approval of Training Schools for Radiological Technicians. Students in these programs are eligible for the \$140 per month living allowance paid by OHSC and there are no tuition fees.

¹⁶Ontario Department of Education, *Colleges of Applied Arts and Technology*, Programs 69/70, C.A.A.T. Chart No. 3, April, 1969.

Two Colleges of Applied Arts and Technology have established programs for radiological technicians. Confederation College in Thunder Bay offers a five-month program of lectures, laboratories and demonstrations, after which students go to one of three hospitals in the Lakehead for one year and seven months of practical training. At Fanshawe College in London, students sponsored by a hospital operating a training program for radiological technicians approved by the Board of Radiological Technicians take three eight-week sessions of didactic training at Fanshawe with the intervening time spent in the hospital to complete two years of didactic and clinical training.

The central issues before the Committee in the area of education was the structure and control of such training programs.

The Committee considered four possible systems for the training of health technologists:

- 1) To leave the training of health technologists under the control of the Department of Health and OHSC, encouraging the development of the regional schools funded by OHSC.
- 2) To encourage a multi-phasic approach towards the training of health technologists, leaving hospital and regional schools as they are but introducing new programs into Colleges of Applied Arts and Technology as feasible, and to leave the approval of all programs in the hands of the Canadian Medical Association accreditation committees.
- 3) As 2) but to remove the accreditation of these programs from the Canadian Medical Association accreditation committees, placing it in the hands of an Advisory Committee in the Department of Education while at the same time, developing a certification process at the provincial level to replace that carried out by the voluntary association.
- 4) To phase out the hospital schools as feasible and transfer the regional schools to the jurisdiction of the Department of Education, while at the same time encouraging the development of schools of health technology in Colleges of Applied Arts and Technology, and developing an Advisory Committee and certification process as in 3).

The Committee has carefully reviewed these possibilities and, while recognizing that there may be considerable problems in making such a transfer, recommends the adoption of the final alternative, 4). This recommendation corresponds to our recommendations regarding control of the education of other groups, such as nurses and health therapists. If the location of facilities or other considerations make such a transfer inappropriate in some particular cases, the physical location of the educational program might remain outside a college, while the control is transferred to the Department of Education.

By placing the control and conduct of the education of these groups under the Department of Education, the Committee hopes that some economies of scale will result from the centralizing of facilities and teaching resources. At the same time, the Committee sees advantages to the students through the opportunity to mix with other groups in the health field during their educational period. The Committee also hopes that experimentation will be encouraged in these educational programs and suggests that consideration be given to the development in at least one school of a basic paramedical training program which in its first year would provide a common core program for many groups entering the health field at the technical level. Developments in British Columbia and Alberta in their Institutes of Medical Technology are beginning to indicate the larger pattern possible for the training of these groups.

The Committee recognizes the great contribution which the medical profession has made in the development of training programs for health technologists, and the time and dedication of many members of that profession in drawing up criteria, conducting survey programs, and devoting much effort to the emergence of improved educational programs for health technologists. However, the Committee believes that these programs have now reached the point where they should be controlled by the institutions in society responsible for education. It will be necessary to have the continued cooperation of those already working in these occupations and of the medical profession, as well as that of hospitals, which will remain responsible for providing the facilities for much of the practical experience required. The Committee suggests that appropriate advisory and joint committees be developed to ensure that the education received by students in health technology is in line with the anticipated needs of the institutions in which they will later be working.¹⁷

Recommendations:

- 252** That control of education programs for health technologists be transferred to the Department of Education; and that a Health Technology Education Advisory Committee be established to advise the Minister of Education on proposed educational programs for health technologists and the length and content of such programs.
- 253** That new programs in health technology should be conducted in Colleges of Applied Arts and Technology and that existing programs in hospitals and regional schools be transferred to such colleges as feasible.
- 254** That training bursaries or such general grants as are necessary to attract appropriate numbers into the training programs for health technology should be made available by the Province of Ontario without reference to the type of institution in which training is undertaken.

¹⁷See Chapter 26.

An important step in the direction of developing combined facilities for the training of health technology personnel has been undertaken by the Toronto Institute for Training in the Technological Aspects of Medicine, where plans have been made to train laboratory and radiological technicians as well as other newer paramedical personnel. As discussed above, however, we consider it advantageous that the actual training programs be conducted within the context of an institution under the control of the Department of Education. In this case, we recommend the affiliation of the Toronto Institute with a College of Applied Arts and Technology or with Ryerson Polytechnical Institute as a major division of one of these institutions. We expect that advisory committees would be established to assist the health sciences division of such a college in the development of its educational programs, the internship portions of the training and the placement of students. We also recommend that health sciences divisions be developed in other Colleges of Applied Arts and Technology.

The Toronto Institute then would continue to play an important role in the field and, with its teaching function transferred to an educational institution, would be free to concentrate on research into the education of technological personnel and the development of pilot programs for training new types of personnel.

Recommendation:

- 255** That the teaching function of the Toronto Institute for Training in Technological Aspects of Medicine be incorporated into a health sciences division of a College of Applied Arts and Technology or Ryerson Institute, and that Colleges of Applied Arts and Technology develop health science divisions to coordinate the training of workers in the health sciences, including health technologists.

The Canadian Medical Association committees which have been involved in developing accreditation standards for educational institutions training medical technologists and radiological technicians have been largely responsible for the maintenance of the high standards of education of these groups available in Ontario. We believe, however, that with the changes recommended, accreditation by the voluntary associations will no longer be required but can more appropriately be done by the Advisory Committee.

Recommendation:

- 256** That accreditation of education programs for health technologists be undertaken by the Health Technology Education Advisory Committee.

Entrance Requirements and Length of Program

To date the entrance requirements for medical laboratory technologists have been seven subjects in grade thirteen, leading to a two-year training program. For radiological technicians, a minimum 60 per cent average in grade twelve is required to enter a two-year training program.

Courses in medical laboratory technology and radiological technology recently established at Colleges of Applied Arts and Technology, however, require for entrance only the completion of grade twelve of the five-year stream of secondary education in Ontario. The course in medical laboratory technology offered by Algonquin College was the first of these new programs. It consists of six semesters and is didactic in format. Students take the first three semesters consecutively from September to September. This is followed by a recess of one semester during which time hospital-affiliated students spend ten weeks in a period of orientation at their sponsoring hospital. The remaining three semesters follow consecutively from January to January.¹⁸ Following this a further ten months' internship is required on an approved program before the student is eligible for certification with the Canadian Society of Laboratory Technologists.

The Committee is reluctant to suggest increasing entrance requirements and extending educational programs for any health discipline unless it is evident that such changes are absolutely necessary in order to ensure adequate quality of practitioners. We believe that programs should be developed to allow students with completion of any grade twelve program to enter educational programs for health technology, but that those entering with grade thirteen be given advanced standing. In this connection, we note that Algonquin College allows grade thirteen graduates to enter the third semester of its program.

Recommendation:

257 That the Health Technology Education Advisory Committee keep under constant review the entrance requirements and length of courses required for radiological technicians and medical laboratory technologists.

We are also of the opinion that certification as a technologist should follow upon the completion of two years of formal training, without the additional requirements of a third internship year. Incorporated into this formal program should be adequate practical experience to prepare the student for employment as a junior technologist upon graduation. As in the case of the two-year program in nursing, employers should recognize that such graduates may require a period of orientation in hospital procedures and close supervision until they are fully experienced to work on their own. The OHSC should also recognize this junior grade technologist with appropriate salary provisions.

Opportunities for the students to work directly in hospitals during their educational programs are essential. Such hospital experience, however, should be arranged through consultation between the educational institutions and the hospitals in order that the educational component of such experience should remain predominant.

¹⁸*Calendar*, Algonquin College of Applied Arts and Technology, Ottawa, 1969-1970, p. 103.

Recommendation:

258 That educational programs for health technologists such as the one for medical laboratory technologists offered at the Algonquin College of Applied Arts and Technology be encouraged and that the arrangement of the didactic and practical portions of programs be undertaken in a variety of ways. As the Committee has reservations regarding the necessity of lengthy internship periods for health technologists this aspect of the training should be reviewed closely by the Health Technology Education Advisory Committee.

The Committee has studied the practice in the United States of requiring the completion of either three or four years of college or university before admission to medical technology courses. In light both of the demand for such personnel and of the functions they undertake in this province, we believe that such requirements are generally not necessary in the Ontario context; nor do we believe that the development of these disciplines at the university level is an appropriate or practicable solution at this time.

Education of Emerging Occupations

The field of health technology, as we have noted earlier, has been marked by a continuing proliferation of new groups specializing in particular skills. The emergence of such personnel is a function of the requirements of employing agencies who have, in most cases, developed their own specialty technologists through on-the-job training. However, some of these groups have now reached the point where there are sufficient numbers to make possible more formalized training. In particular, the Committee feels that the need for electroencephalograph technicians, medical electronics technicians and inhalation therapy technicians call for the development of centralized and formal training programs operated under the same auspices as for laboratory technology and radiological technology.

The first steps in this direction have been taken by the Algonquin College of Applied Arts and Technology which instituted in 1967 a two-year course for biomedical engineering technicians. Fourteen students graduated from this course in 1969, while twenty-four were enrolled in the first year of the course. Fanshawe College of Applied Arts and Technology began offering a course for inhalation therapy technicians in the 1969-1970 session. Students will be sponsored by hospitals for the two-year course and will spend most of their second year gaining practical experience in the hospital. In accordance with our previous recommendations, we advocate the development of other such programs within the jurisdiction of the Department of Education.

Recommendation:

259 That the Department of Education ensure that appropriate training programs are established for electroencephalograph technicians, medical electronics technicians and inhalation therapy technicians.

It may be necessary in the future to develop other specialties as the demand for them indicates, and the Ontario Council of Health as well as the Research and Planning Branch of the Department of Health should keep in close touch with developments in the field to be able to advise on the appropriateness of recognition of a new group as a separate entity and recommend establishment of formal training programs.

Moreover, we emphasize in this context our concern that not only the types of skill but also the levels of skill required in health technology occupations be recognized in educational programs as in other formal provisions. We are concerned that in some instances education of such groups may be prolonged beyond that essential for the conduct of their occupation, and we suggest that pilot and experimental projects be initiated to determine the optimum length of programs required.

We realize, of course, that for some very highly specialized functions, only an individual hospital can train a person appropriately. A broad background in health technology enabling the technologist quickly to adapt to the particular requirements of the hospital undoubtedly provides the best formal preparation for the performance of such functions.

The smaller hospital, on the other hand, will not have the same requirements for specialist technicians but may instead require a more general type of technologist who can assist in a number of functions. Special attention should be given to this problem, and the regulation of health technologists should not be such as to eliminate the possibility of persons acting in a general capacity as required.

Advanced Education

At present, the Canadian Society of Laboratory Technologists grants an Advanced Registered Technologist certification to those persons who have completed the required course work and practical experience through a system of credits and also a licentiate upon further appropriate advanced study. No formal advanced educational programs are available to radiological technicians.

The Canadian Society of Laboratory Technologists has done commendable work in upgrading and maintaining the standards of competence of its members. However, it now appears that advanced educational programs for medical technologists could appropriately and profitably be offered by institutions training basic health technologists, within the control of the Department of Education. Under such a system, graduates of these programs should be awarded recognition by the Health Disciplines Regulation Board.

It is also necessary that appropriate job classifications and pay schedules be developed, and the cooperation and advice of those in health technology and allied professions will be required in developing such programs. We foresee the need for increased numbers of technologists with advanced qualifications to fill positions as teachers and supervisors as well as specialists in particular aspects of health technology. Some of these personnel, especially teachers, may be trained

in university programs. Hence advanced training and certification should be developed in the fields of teaching and administration as well as in such practical areas as blood bank, cytology, histology, clinical chemistry, bacteriology, haematology, virology, serology, nuclear medicine and radio-isotope medicine.

Recommendation:

- 260** That opportunities for health technologists to undertake advanced training be made available at educational institutions teaching health technology, and that the academic portion of such programs be under the control of the Department of Education.

Refresher Courses

One further type of educational program in health technology deserves consideration here. We have noted above the high attrition rate among health technologists, attributable in large part to the fact that female technologists retire from the field after marriage. There would appear to be a pool of manpower among such inactive technologists who may wish at a later point to re-enter the field but who require some retraining. The effective realization of this potential requires that refresher courses be available to those seeking to re-enter the field of health technology.

Recommendation:

- 261** That refresher courses be sponsored for health technologists in order to attract into employment some of the qualified technologists not presently employed. Such courses should be made available through the educational institutes training health technologists in cooperation with affiliated hospitals.

Educational Planning and Recruitment

In this chapter we have made some specific recommendations concerning the education of health technologists. But the planning of an integrated and coherent system of education for these groups must be a continuing process. In addition to the types of consideration which have concerned us in this section, such a planning process must take cognizance of the effects of the types and locations of educational programs upon the distribution of the supply of health technologists—both among specialties and among geographical areas—and should ensure an appropriate functional and geographic distribution of programs. In addition, activity directed towards recruitment into these programs could profitably be intensified within the general education system.

Recommendation:

- 262** That hospitals and others concerned with the need for health technologists make information available to students about job opportunities and the kind of skills required for careers in health technology. This should be done both in high schools and in universities.

Regulation

At the present time in Ontario, health technologists do not require a licence to practise. Indeed, the most formal of the regulatory provisions in this area is that of certification, and applies in the case of radiological technicians. The Board of Radiological Technicians (composed of four radiological technicians recommended by the Board of Directors of the Ontario Society of Radiological Technicians, two radiologists recommended by the Section of Radiology of the Ontario Medical Association, and one person, not a radiologist, recommended by the Ontario Medical Association from its secretariat) maintains a Register of those persons who have complied with its educational and examination requirements.¹⁹ While such registration carries with it the exclusive right to the use of the designation "Registered Radiological Technician", it is not mandatory for employment as a radiological technician.

In the case of the other health technologist groups—medical laboratory technologists, electroencephalograph technicians and inhalation therapy technicians—the voluntary association certifies members who have met certain standards established by the Association. There is as yet no voluntary association for medical electronics technicians or electrocardiography technicians.

In what follows we shall make several recommendations concerning the regulation of health technologists. These recommendations are tied closely to our previous recommendations concerning education, for the two together would form the new structure under which health technology would develop in the province.

We do not believe that licensure of health technologist groups is required at the present. Because health technologists work under supervision, rather than independently, restriction of practice to those possessing a licence is not necessary. Moreover, we do not think it appropriate that these occupations acquire the status of self-governing professions.

Instead, we propose that a system of provincial certification be established. Certification of health technologists by an impartial body will give employers a standard by which to judge the qualifications of prospective employees; however, we feel that it is the responsibility of the employers to determine whether or not certified personnel are hired. We realize that in some cases, rather than cutting essential services, employers will have to employ persons who have not yet reached certification standard.

The system of certification should be administered by the Health Disciplines Regulation Board (see Chapter 25) which, on the advice of a Health Technologist Division, will establish certification standards for the health technologist occupations. The Board should be given the corollary power to suspend or cancel certi-

¹⁹S.O. 1962-1963, c. 122, s. 14. The Radiological Technicians Act also contains a "grandfather clause" allowing for registration of practising technicians who, at the time the Act was passed, met specified conditions.

fication. We anticipate, however, that this power would be little used, since most of the health technologists are employees whose employers are primarily responsible for their discipline.

Similar considerations—the facts that technologists function in generally supervised situations, and that employees are primarily responsible for ensuring that technologists maintain competence and keep up to date with new techniques and developments—have led us to conclude that a recommendation of compulsory continuing education is not warranted.

We do believe, however, that technologists should be certified annually or every two years, and that recertification should not be automatic if certification has lapsed for three years.

Recommendations:

- 263** That health technologists be certified by the Health Disciplines Regulation Board through a Health Technologists Division.
- 264** That the Health Disciplines Regulation Board attempt to develop standards of certification which will be recognized by other provinces in Canada and promote nation-wide recognition of standards to facilitate the mobility of health technologists.
- 265** That the Health Disciplines Regulation Board be empowered to certify health technologists trained outside Ontario who have received training equivalent to that required in Ontario, and that the Board have power to determine such equivalents.
- 266** That those technologists trained within Ontario at institutions accredited by the Health Technology Education Advisory Committee, upon receiving the appropriate diploma, be certified by the Health Disciplines Regulation Board without further examination.
- 267** That a health technologist who has not been employed in his field for a period of three years and has not maintained his certification should be required to take a refresher course at an appropriate educational institution before being eligible for recertification.

Chapter 19 Medical Laboratories, X-Ray Laboratories and Clinical Chemists

Private Clinical Laboratories

The Committee was directed by its terms of reference to inquire into “the present position and merit of the services, duties and responsibilities of those operating or engaged in providing services through independent biological or diagnostic laboratories”. To assist us in discharging this aspect of our obligation, we commissioned Chemical Engineering Research Consultants Limited (CERCL) to study private clinical laboratories in Ontario. A report of this study, the results of which pertain to 1967, has been published separately.¹ This chapter draws primarily upon the information submitted in the CERCL report, as well as upon information provided in hearings with clinical chemists and others.

As we wished to obtain some indication of the extent of the danger to the Ontario public arising from inaccurate test results, CERCL undertook a quality survey as part of their report. This was an area which had aroused much public concern, a concern reflected in conflicting statements made before the Committee. We have heard the quality of testing in private laboratories in Ontario variously described as poor,² as generally good,³ and as exhibiting great variety among laboratories.⁴

Examination of material taken from the human body, usually tissue, blood or urine, is often an essential part of the diagnosis of disease, and this examination is most conveniently performed in a clinical laboratory organized to perform a variety of tests. Clinical testing is carried out by hospital laboratories and by public health laboratories of the Department of Health, as well as by private laboratories and by physicians in their own offices.

As changing medical technology has resulted in an increase in the complexity and scope of the tests which can be performed to aid the physician in the diagnosis

¹Chemical Engineering Research Consultants Limited, *Private Clinical Laboratories in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969.

²J. C. McLauren, Transcript of the Hearings of the Committee on the Healing Arts, April 4, 1967, p. 2201.

³Canadian Society of Laboratory Technicians, Transcript of the Hearings of the Committee on the Healing Arts, April 4, 1967, p. 2081. Ontario Society of Medical Technologists, Transcript of the Hearings of the Committee on the Healing Arts, April 4, 1967, p. 2151.

⁴Dr. D. M. Young, Director of Laboratories, Toronto General Hospital, and Dr. J. C. Porter, Director of Clinical Chemistry, Toronto General Hospital, Transcript of the Hearings of the Committee on the Healing Arts, October 24, 1967, *passim*.

and treatment of his patient, the volume of laboratory testing in general has greatly increased. The tests which can be done by medical laboratories now number approximately 300, although twenty common tests constitute approximately 90 per cent of the work load. A number of blood and urine tests have become a standard part of the examination of patients; and while a few of these tests can be performed quickly and easily by either a physician or his nurse, others require complex equipment or time-consuming procedures. The greatest part of the development and expansion of laboratory facilities to perform such tests has taken place in hospitals, with the result that laboratory tests have been most readily available for the diagnosis and treatment of hospitalized patients. The need for complex tests is not confined to the hospital setting, however; many are also of great use to health practitioners, predominantly physicians, in their practice outside the hospital. And while many hospitals will perform tests prescribed by physicians for non-hospitalized patients, they lack both the capacity and the organization to do all the tests required.

In response to this problem there has been a rapid increase over the past two decades in the number of private medical laboratories in Ontario. A number of factors operate to encourage physicians to have tests done in these facilities, rather than in hospital laboratories or in their own offices. In the first place, as noted above, the overburdened hospital laboratories may not be able to perform all of the tests desired by the physicians. Even when the desired tests can be performed by hospital laboratories, private facilities may offer advantages in terms of time and convenience. The lag in the receipt of results is likely to be greater in the case of hospital laboratories than in that of private facilities. Furthermore, private laboratories may be more conveniently located to the physician's office than is the hospital; some, for example, are situated in medical arts buildings. The use of private laboratories offers advantages in terms of the patient's convenience, as well as the physician's, since in many cases it obviates the necessity that the patient be hospitalized for tests. Indeed, some private laboratories make provision for home calls to take samples, thus sparing bedridden patients a trip to the physician's office or to a hospital outpatient clinic. In the face of the increasing difficulty experienced by physicians in obtaining hospital beds for their patients, this service becomes particularly important.

One further consideration has led physicians to turn to private laboratories in the face of difficulties with hospital facilities, rather than perform even the more simple tests in their own offices. Most medical insurance schemes, including Ontario Health Services Insurance Plan (OHSIP), cover the costs of clinical tests performed in private laboratories when the tests are ordered by a physician and when the laboratory meets certain standards, but generally do not reimburse the physician for tests he performs himself. Such coverage, in encouraging the physician to prescribe tests more freely, has added to the total volume of such tests being performed and has put pressure on all available laboratory facilities.

These factors have all affected the growth in the number of private laboratories. At the time of the CERCL study in 1967 there were 112 private clinical laboratories in Ontario. Seventy-two of these were individual laboratories offering a wide range of tests, thirty-three were part of four "chains" of laboratories, and seven offered limited services in specialized fields such as cytopathology. The rapidity of growth is indicated by the fact that only 15 per cent of the laboratories were founded before 1950, while 50 per cent have been established since 1963.

Organization

The great majority, approximately 75 per cent, of the private laboratories in Ontario are located in physicians' offices, commercial buildings, or—in the case of six of the laboratories in one chain—in hospitals. Within the group of individual laboratories, 33 per cent have been incorporated, the remainder being owned by individuals or by groups of individuals. On another basis of classification, 20 per cent are owned by one or more medical specialists, principally pathologists; 22 per cent are owned by physicians with part ownership by a pathologist; 48 per cent are owned by one or more physicians; and 10 per cent are owned by chemists, technicians, or non-profit making groups.⁵

The requirements of the insuring agency influence the form of ownership and organization of these laboratories. OHSIP will pay only for analyses performed in laboratories registered under their plan, where the test must be conducted under the supervision of a physician. The laboratory may be owned by non-physicians as long as there is appropriate medical supervision of the work. A number of laboratories which do not meet this requirement do not have the work covered by the insurance plan. In order for a new laboratory to be accepted under OHSIP, information regarding its planned organization, operations, and tests to be performed must be submitted to the Medical Adjudication Branch of OHSIP, and approval given by the Medical Board.

Of the four chains of laboratories, one is wholly owned by a physician; one, which operates laboratories in six hospitals, is owned by fourteen physicians; one is run by a Board of eleven directors, six of whom are physicians, and has thirty shareholders; the fourth chain of sixteen laboratories is supervised by a group of three pathologists, with the laboratories owned by the physicians who occupy the medical buildings in which these facilities are located.

The average laboratory deals with twenty physicians, although some may deal with as many as 300. Our study found that the physician-laboratory contact is usually good when the laboratory is located within a medical building; but when the laboratory is located in a commercial building, most physicians visit the laboratory only infrequently.

⁵CERCL, *op. cit.*, p. 7.

Quantity and Scope of Testing

Table 19.1 shows an estimate of the quantity of testing done in private laboratories, hospital laboratories and Department of Health laboratories, classified by numbers of tests and by Dominion Bureau of Statistics units. The DBS units are assigned to each test according to the amount of work involved in carrying out the test.

TABLE 19.1
Estimates of Clinical Testing in Ontario, 1966

	Number of Tests	Dominion Bureau of Statistics Units No.	%
Independent private laboratories	1,364,000	3,500,000	6
Chains of private laboratories	556,000	1,400,000	2
Public health laboratories ¹	398,000	2,109,000	3
Hospital laboratories ²		56,520,000	89
Total		63,529,000	100

¹Clinical pathology specimens.

²Includes inpatients and outpatients and referred work, but not work sent outside.

SOURCE: CERCL, *Private Clinical Laboratories in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1969, p. 24.

It should be noted that about 40 per cent of hospital tests are of a type rarely, if ever, attempted by private laboratories, such as those related to autopsy, surgical pathology, electrocardiographs and electroencephalographs.⁶ The percentage of biochemical, haematological and urinalysis tests performed by private laboratories is 12 to 15 per cent of the provincial total. Except for the few strictly specialized laboratories, most of the private laboratories offer simple biochemical analysis, haematology and urinalysis tests. Although the distribution of testing among these areas varies in each laboratory, the annual average amount of testing performed by the independent private laboratories in 1966 was 18,890 tests, with haematology tests constituting 55.0 per cent of the total; biochemistry, 20.1 per cent; urinalysis, 11.7 per cent; cytology, 6.3 per cent; and microbiology, serology, pregnancy and blood bank tests taking up the remaining 6.9 per cent. A similar pattern of testing appears in the laboratories in the four chains. The average distribution, of course, ignores the fact that some laboratories do not offer services in all the areas listed above. Approximately 40 per cent of the laboratories offer some microbiology services; 60 per cent, serology; and 30 per cent cytology.⁷

⁶*Ibid.*, p. 24.

⁷*Ibid.*, p. 8.

Personnel

As supervision of tests by a licensed physician is both required by OHSIP as a condition of its coverage and recommended by the Ontario Medical Association, most laboratories conform, if only nominally, to this requirement. The insurance plan does not insist upon the director's knowledge of any specialized area of medicine, such as pathology, however, and does not inspect laboratories to determine the amount of time he spends in each.

At the time of our study (1967) there were 365 technical personnel employed in private laboratories. Fifty-nine per cent of them were registered technicians;⁸ the remainder had received formal training abroad or had been trained on the job. Approximately one-quarter of the technical staff in private laboratories work part time, this group consisting mainly of married women and hospital technicians.

Quality of Service

Error variance in test result — that is, the difference between the test result obtained by a laboratory and the true value — can arise from a number of factors, such as improperly taken samples, use of reagents of incorrect strength or composition, equipment faults, or incorrect techniques.⁹ There is no general agreement on what the range of acceptable deviation from the true value, or the "error limit", should be; hence there exists no hard and fast criterion for the evaluation of laboratories in terms of the percentage of their results which are unacceptably erroneous. Probably the most important error limit is that defined by the physician, the point beyond which he might medically mismanage the patient.¹⁰ But in very few cases does the patient's treatment depend entirely on the result of one test; generally, analysis of a sample only contributes to the diagnosis, and the extent of the contribution depends upon the nature of the disease and the physician's diagnostic skill.¹¹

It is obviously important to minimize error variances and thus to improve the information conveyed by analyses. A competent laboratory director is aware of sources of error and takes precautions against them; but it is also necessary for a laboratory to have a quality control program to provide a regular check on the accuracy of analyses, preferably without the knowledge of the technician performing the analyses. A quality control program becomes increasingly important as automated equipment is introduced in laboratories; for the speed of analyses multiplies the number of unacceptable results that can be produced unless careful checks are carried out frequently.

⁸This is the terminology used in the CERCL report, *ibid.*, p. 19. Since these personnel have met the requirements set by a professional body, such as the Canadian Society of Laboratory Technologists, they are in effect "certified" technicians.

⁹CERCL, *op. cit.*, pp. 27ff.

¹⁰*Ibid.*, p. 35.

¹¹Canadian Society of Clinical Chemists, Transcript of the Hearings of the Committee on the Healing Arts, October 16, 1967, pp. 26-30.

A detailed description of the quality survey methods and results can be found in the report by the Chemical Engineering Research Consultants Limited; here we will merely indicate a few of the findings.¹² The tests for our survey were limited to the biochemical field, where the results could be assessed quantitatively and comparisons made among the laboratories. Control samples were sent to one reference laboratory and the following analyses were requested: glucose, blood, urea, nitrogen, sodium, calcium, phosphorus, total protein, bilirubin and transaminase. It was found that the accuracy of the private laboratories is generally comparable or slightly inferior to the average accuracy of Toronto hospitals, and definitely inferior to the accuracy of the larger, well-equipped hospitals; but the level of accuracy is not such as to give any cause for alarm. Most laboratories are providing a responsible, medically useful service. As those in the laboratories knew that these samples were being run as part of an evaluation program, however, it is likely that the accuracy as measured by our survey represents the best that the laboratory can do. In the light of this consideration, it is evident that there is room and need for improvement.

Although all the laboratories visited expressed interest in quality control, very few had adequate quality control programs. Quality control requires more than the occasional running through of purchased serum; a constant watch must be maintained to detect deterioration of accuracy. Since the object of our survey was merely to obtain an estimate of the accuracy of laboratories in Ontario, only single samples were sent out to each laboratory. The quality that really matters, however, is the ability of the laboratory to maintain its accuracy on a day-to-day basis. Therefore, any compulsory quality control program should be on a regular basis, and should include assessment by qualified inspectors of the accuracy of tests.

Regulation

There are at present no restrictions on the establishment of private clinical laboratories in Ontario; however, under the Public Health Act, the Department of Health is empowered to issue regulations to govern the operation of all "medical and health" laboratories.¹³ Although no regulations had been issued at the time of writing (1969), it was expected that some form of regulation would be introduced in the near future.

In view of the importance of the maintenance of a service of good quality in all health laboratories, the Committee believes that the Health Facilities Board described in Chapter 24¹⁴ should establish a licensing system to apply to all medical and health laboratories in the province. We believe it is in the public interest that all laboratory facilities be subject to minimum standards and to

¹²CERCL, *op. cit.*, pp. 27-43.

¹³R.S.O. 1960, c. 321, as amended by S.O. 1967, c. 79.

¹⁴The Health Facilities Board will have functions extending beyond the field of clinical laboratories to include the inspection of pharmacies and the licensing of dental laboratories. See Chapter 24.

inspection by a team of qualified inspectors acting under the authority of a government agency. In addition, the Health Facilities Board should undertake the development of quality control programs including, if necessary, a review of "kits" of prepackaged reagents used by many laboratories. Funds should be made available to the Board to undertake research into quality control and new techniques, and the Board also should be able to contract with other persons or laboratories to undertake such research leading to the improvement of laboratory methods.

We did not encounter any strong opposition to the licensing of laboratories on the part of any of the organizations that appeared before the Committee. The College of Physicians and Surgeons of Ontario in its brief to the Committee on the Healing Arts called for a provincial system for the inspection and control of diagnostic laboratories;¹⁵ and the brief of the Doctors' Clinical Laboratory, a private laboratory, recommended a government agency to licence and regulate private laboratories.¹⁶ Only 4 per cent of the laboratories surveyed by CERCL opposed licensing.¹⁷

The Committee is persuaded that insurance payments for tests should be made not only to laboratories directed by physicians, but to all laboratories that have been licensed. We believe that there are persons, other than physicians, possessing appropriate scientific qualifications, who are competent to direct a laboratory, and that this fact should be recognized in the standards laid down for personnel. A clinical chemist, for example, usually is more familiar with tests in the field of clinical chemistry than most physicians and consequently may be better able to direct a laboratory conducting such tests.¹⁸

Recommendations:

- 268** That legislation be enacted for the licensing of private clinical laboratories and that such legislation permit the supervision of such laboratories to be under the control of either qualified physicians or persons with an adequate background in scientific fields, as applicable. The Health Facilities Board should be responsible for the administration of this licensing program, as well as for the establishment of standards for clinical laboratories, the determination of qualifications for personnel working in such laboratories, the inspection of clinical laboratories, and the development of quality control programs and programs to improve techniques and quality in the laboratory field.

¹⁵College of Physicians and Surgeons of Ontario, Brief to the Committee on the Healing Arts, Part 2, 1967, p. 11.

¹⁶Doctors' Clinical Laboratory, Brief to the Committee on the Healing Arts, 1966, p. 15.

¹⁷CERCL, *op. cit.*, p. 51.

¹⁸See the discussion of clinical chemists later in this chapter, pp. 441-443.

- 269** That insurance payments from the Ontario Health Services Insurance Plan for laboratory tests should not be restricted to those laboratories where the tests are conducted under the supervision of a physician, but should be available to any licensed laboratory.
- 270** That laboratories and x-ray facilities in hospitals should be covered by the regulations governing clinical laboratories and x-ray laboratories, and that the Ontario Hospital Services Commission may designate the Health Facilities Board to undertake inspection of such facilities in hospitals.

The basis for remuneration of private clinical laboratories is the fee schedule of the Ontario Medical Association (OMA). Since the OMA fee includes an allowance for an interpretation by a pathologist, and since this interpretation does not normally take place in the case of private laboratories, the fee is undoubtedly generous for the amount of work done. The disproportion is likely to increase as automation reduces further the labour involved in performing many tests. In view of these considerations, the CERCL report found the OMA fee schedule to be in need of review, in order to pass along to the public the savings effected by automation and to remove the professional interpretative component where it is not applicable.¹⁹ We believe that, like other fees for health services, the fees charged for laboratory tests should be under constant review by the Department of Health and should not be determined unilaterally by a professional body. Since we envisage licensed laboratories under the supervision of appropriately trained scientific professionals and not necessarily physicians, it would be inappropriate to continue to permit fees for laboratory services to be determined by a voluntary association of physicians. Instead, such determinations should be the result of negotiations between the Department of Health and the laboratories. Here the Fee Negotiations Advisory Committee should play a role in providing appropriate advice to the government.

Recommendation:

- 271** That fee schedules for tests performed by clinical laboratories should be a matter of prior negotiation by the clinical laboratories and the Minister of Health who would be advised by the proposed Fee Negotiations Advisory Committee.

The Committee also believes that osteopaths who are qualified to practise in Ontario should be included in any class of personnel who may send specimens to laboratories, and that osteopaths should be able to have tests done which are relevant to their practice with the results of these tests being reported to them.²⁰

¹⁹CERCL, *op. cit.*, pp. 14-15.

²⁰See also Chapter 20.

Recommendation:

- 272** That licensed osteopaths be permitted to send specimens to licensed laboratories for tests which are relevant to their practice, and that the laboratories be required to report the results to them.

X-ray Laboratories

X-ray facilities are controlled by regulations made under the Public Health Act.²¹ The regulations, filed in January 1969, require that all owners of x-ray machines register with the Minister of Health. The therapeutic use of x-rays is limited to physicians with specialist certificates in radiology or dermatology, and the diagnostic use to physicians, dentists, chiropractors, osteopaths and chiropodists. These classes of personnel, however, may delegate the handling of the x-ray equipment to registered radiological technicians, or to a person who in the opinion of the prescriber is adequately trained, subject to appropriate supervision.

New x-ray installations must be approved by the Department of Health; and information regarding the premises where the machines will be located, the shielding for the machines, and the owner is required by the Department. Inspectors also may be appointed by the Department who may require the owner of an x-ray source to furnish information regarding the use of the x-ray source, qualifications of x-ray workers, and protective procedures. They may conduct technical tests to establish x-ray dosages. An owner not complying with the requirements of the Department may be required to discontinue the use of an x-ray source until such changes have been made respecting it or its manner of operation as the Department may direct. The Public Health Act stipulates that anyone contravening the Act or its regulations is guilty of an offence and on summary conviction is liable to a fine up to \$500.²²

The Committee did not conduct any specific research into x-ray facilities. But in view of the dangers which can result both to the patient and to others in adjacent premises through improper use of x-ray sources, we endorse the existing regulations. We believe that it would be appropriate for the administration of these regulations to come under the jurisdiction of the Health Facilities Board, which would also provide the inspection staff.

Recommendation:

- 273** That the regulations governing the installation and use of x-ray sources should be administered by the Health Facilities Board.

²¹O.R. 29/69.

²²R.S.O. 1960, c. 321, s. 116 (2).

Clinical Chemists²³

Clinical chemistry, which is also termed chemical pathology, clinical biochemistry or pathological chemistry, is the application of chemistry to the human body to assist in the diagnosis and treatment of disease. Although some clinical chemists teach in universities or work in government, in research or in private laboratories, the majority of clinical chemists work in hospitals. Some clinical chemists may hold only a Bachelor's degree, while those who are more highly qualified have very advanced education and training with a degree in medicine as well as a Ph.D. in a biological science.

The duties of the clinical chemist in a hospital will vary with the size of the hospital and the research facilities available. The clinical chemistry department may be a division of the Department of Laboratories, Medicine or Pathology, or it may be a separate department. The clinical chemist may supervise the operation of the laboratory, including the selection of analytical methods to be used, and establish a quality control program. He may also supervise the biochemical research laboratory, if the hospital has one, and carry out independent research projects. As an expert in biochemistry, the clinical chemist is a consultant for other members of the hospital staff, and may teach biochemistry to residents, internes, nurses and technicians.

Training

Clinical chemistry embraces the fields of both science and medicine and has developed as a separate profession only in the past two decades. The primary requirement for a clinical chemist is a wide knowledge of all branches of chemistry: inorganic, analytic, organic and physical chemistry; biochemistry; and radio-isotope. He must also possess a working knowledge of anatomy and physiology. Because the practice of clinical chemistry is not regulated and does not require a licence, there is no fixed training route along which all clinical chemists must pass.

A number of new programs have been established in recent years in Canadian universities which provide training in clinical chemistry at undergraduate, graduate and post-doctoral levels. At Laval University a program leading to a Ph.D. is offered for biochemists who intend to work in clinical laboratories; it includes courses in analytical chemistry, quality control and instrumentation. At the undergraduate level, the University of Waterloo has included hospital clinical chemistry among the areas selected for practical training in the five-year honours chemistry program. Under this program, the student divides his time between academic training at the university and practical training in a hospital laboratory.

²³Although no separate study of the educational and regulatory structures for clinical chemists was undertaken by the Committee, hearings were held with the Canadian Society of Clinical Chemists, and with Dr. D. M. Young, Director of Laboratories, Toronto General Hospital, and Dr. J. C. Porter, Director of Clinical Chemistry, Toronto General Hospital.

At the University of Toronto and at the University of Western Ontario, the departments of pathological chemistry offer undergraduate courses in general pathological chemistry, graduate courses in advanced pathological chemistry, and recent advances in analytical chemical pathology. Toronto offers one graduate course in clinical chemistry which emphasizes modern instrumentation, comparative methodology and quality control.

Two new programs were established in 1968. At the University of Windsor a Master's degree in clinical chemistry is offered in the Biochemistry Department. During the two-year course the student spends part of his time in a hospital laboratory. At the University of Toronto, in the Department of Pathological Chemistry, Faculty of Medicine, a two-year post-doctoral diploma course in clinical chemistry has been established. The course is open to Ph.D.'s in biochemistry and to physicians who have taken honour science courses at the undergraduate and postgraduate levels. Five students enrolled in the first year of the course, and it is hoped that more can be admitted as more places are made available for the students in hospital laboratories. Also in 1968, the Royal College of Physicians and Surgeons of Canada established a Fellowship in Medical Biochemistry, with a five-year training requirement, two of which must be spent in clinical chemistry. The University of Toronto diploma will be accepted as the clinical chemistry portion of the Fellowship.

Organization

The Canadian Society of Clinical Chemists was founded in 1957 to advance the practice of clinical chemistry professionally and academically. There are three categories of membership: honorary, full and associate. Full members have degrees in science and/or medicine and have been teaching clinical chemistry or working in the field for at least two years. Associate members are interested in clinical chemistry but do not possess either or both of the qualifications for full membership. In Ontario in 1968 there were eighty-two members of the Canadian Society of Clinical Chemists: one honorary member, fifty-eight full members, and twenty-three associate members.

Of the fifty-eight full members, fourteen are certified clinical chemists. The certification program was introduced by the Society in 1965 to give recognition to those members who, in the opinion of the Certification Committee, possessed "the necessary training and experience to practise clinical chemistry". Applicants for the certification examination must have a Ph.D., D.Sc., or equivalent degree in chemistry or the biological sciences, or an M.D. degree; and they must have completed courses in biochemistry and pathological chemistry at the postgraduate level. Applicants must also have had either three years' full-time experience in a responsible position in a laboratory acceptable to the Committee, or five years' tenure of rank (assistant professor or above) in biochemistry, biological chemistry, clinical chemistry, pathological chemistry, toxicological chemistry or biological assay at a college or university acceptable to the Committee. In 1967 the Society

changed its rules to provide that graduates of a two-year post-doctoral fellowship program approved by the Committee would be eligible for certification without examination. This provision applies to the University of Toronto Diploma Course in Clinical Chemistry.

The Canadian Society of Clinical Chemists is one of the associations which participates in the survey teams organized by the Canadian Medical Association Committee on Approval of Training Programs in Medical Laboratory Technology.

Regulation

Clinical chemistry has not been recognized and regulated as a separate profession by any legislation in Ontario or in any other Canadian province. Practitioners in the field are divided between those who are registered physicians and those who hold degrees in science. One result of this division has been that clinical chemists who are not registered physicians have not been recognized by insurance regulations as competent to direct a laboratory carrying out tests to be paid for by insurance schemes.

In Recommendation 268, the Committee stated its belief that the direction of laboratories should not be limited to licensed physicians but should be extended to persons possessing a suitable scientific background. We believe that clinical chemists are competent to direct laboratories; and, indeed, we know of laboratories in hospitals in which this is the case. The Health Facilities Board, outlined in our previous recommendation, will establish qualification standards for the directors of licensed laboratories. Having recommended this change to remove the major disadvantage of the present situation for the utilization of the skills of these highly trained personnel, the Committee does not believe that further licensing or certification of clinical chemists is required at this time.

With the adoption of this recommendation the field of clinical chemistry should become more attractive to persons who have extensive training in chemistry but do not possess a medical degree. We have noted the new education programs which have been developed in recent years, and believe that this commendable experimentation at different levels of training will increase the number of practitioners in this important and expanding field.

Chapter 20 Osteopaths

The practice of osteopathy in Ontario presents certain problems which are unique in the healing arts. Most of the other professions and disciplines considered in the preceding chapters are practised in other North American jurisdictions in a manner closely similar to that found in Ontario, but this is not true in the case of osteopathy. In most of the states of the United States, osteopaths enjoy a relatively broad scope of practice, similar to that of physicians, and several schools exist for their training. There are no osteopathic schools in Canada, however, and in Ontario the scope of the practice of this discipline has been so narrowly defined and limited by law that osteopaths have been restricted almost entirely to the use of manipulative techniques, and they have practised under the Drugless Practitioners Act.¹ This situation has inhibited the development of osteopathy in Ontario, and consequently only a small group of these practitioners has located in this province.

The Ontario Osteopathic Association regards the terms “osteopathy” and “osteopathic medicine” as being synonymous, and defines the latter, which is in general use today, as:

... a complete school of medicine and surgery utilizing all methods of diagnosis and treatment, placing an emphasis on the relationship of the musculoskeletal system in health and disease.²

Osteopathy is a discipline which had its beginnings in the observations of Andrew Taylor Still (1828-1917), a Missouri frontier medical doctor. After losing his three children in an epidemic of spinal meningitis, he became disillusioned with orthodox medicine and what he considered its excessive reliance on drugs. He became convinced that the human body was self-healing and that total body health depended on the proper functioning of all its systems. In order for the systems to function adequately, an unimpaired physical structure and unimpeded flow of blood and nerve impulses to tissues were necessary. Abnormalities or “osteopathic lesions” in and about the joints of the musculoskeletal system, particularly in the spinal column, resulted in interferences of normal nerve and blood supply. Dr. Still developed a system of manipulation intended to realign the abnormalities, but he also believed that all diseases and disorders could not be treated

¹R.S.O. 1960, c. 114.

²The Ontario Osteopathic Association, Brief to the Committee on the Healing Arts, 1966, p. 3.

with only one form of therapy; consequently, he correlated manipulation therapy with other forms of treatment such as drugs and surgery.³

For more than twenty years, however, the distinction between the osteopath and his medical colleagues in the United States has diminished until, in practice, the main distinction between the modern osteopath and the modern physician is that the osteopath places greater emphasis on the use of manipulation and somewhat less emphasis on drugs than the physician.⁴ The educational standards of osteopathic schools have greatly improved over the same period, and today the pre-professional academic requirements as well as the curricula of these schools are patterned largely after those of schools of medicine. This improvement has been accompanied by an increase in legal and professional status for osteopaths. In forty-two states and the District of Columbia in the United States, osteopaths now have the same privileges as physicians to practise medicine and surgery. In thirty of these states, both osteopaths and physicians take the same licensing board examinations.⁵ As we indicate in a later section of this chapter, however, considerable controversy still surrounds the question of the quality of osteopathic education in relation to medicine.

Manpower

There are about 12,000 osteopaths now practising in the United States. Thirty-seven per cent are located in three states: Michigan, Pennsylvania and Missouri.

In Ontario the picture is quite different. The first osteopathic physicians settled in Ontario about 1900. In 1925, the year osteopaths first became registered under the Drugless Practitioners Act, there were just over 100 of these practitioners in Ontario. For two years prior to that time, osteopaths were registered under the Medical Act of Ontario.⁶ The number of active osteopaths at the time of writing is fifty — only half the total registered in 1925. The total number of active practitioners began its decline about 1950 and reached the figure of fifty in 1969.

There has never been a training program for osteopaths established in Canada, and in Ontario the legal restrictions placed on their practice by the Drugless Practitioners Act since 1925 have prohibited them from using any part of their training except manipulative therapy. The existing limitations on osteopathic practice in Ontario have discouraged osteopaths from coming to this province after completion of their training. This is evident upon examination of the registration figures

³The information on the origin of osteopathy is primarily from Elton Rayack, *Professional Power and American Medicine*, World Publishing Co., Cleveland and New York, 1967, pp. 241-242.

⁴*Ibid.*, p. 242.

⁵William A. Sodeman, M.D., "Osteopathy and Medicine — Undergraduate Education", a paper read before the 65th Congress on Medical Education, American Medical Association Council on Medical Education, *American Medical Association Journal*, Vol. 209, No. 1, July 7, 1969.

⁶S.O. 1923, c. 35.

of the Board of Directors of Osteopathy. Although Ontario has always had the largest number of osteopaths of all the Canadian provinces, the Board has registered only seven osteopaths since 1952, none of whom established a practice in Ontario.⁷

A considerable proportion of the fifty osteopaths who are in Ontario at the present time will reach retirement age in the near future. Seven of these osteopaths are in the forty to forty-nine age group; fourteen are fifty to fifty-nine years of age; nineteen are sixty to sixty-nine years of age; and ten are more than seventy years of age. Most (forty-three) osteopaths are male. Forty-four of them have practised in Ontario for over twenty years, while the remainder have practised for fifteen to twenty years.⁸

Like the majority of healing groups discussed in this Report, the osteopaths practising in Ontario are concentrated primarily in large urban centres. There are only four of the total number practising in cities of less than 20,000, while eighteen practise in cities of 20,000 to 100,000 population, and twenty-seven practise in cities of 100,000 population or larger.

Education

All osteopaths in this province received their training in the United States, the only country which has established formal educational programs for osteopathy. There are presently five osteopathic colleges accredited by the Bureau of Professional Education of the American Osteopathic Association, and this Bureau's decision on accreditation is accepted by the Board of Osteopathy in Ontario. These colleges are

- 1) Chicago College of Osteopathy, Chicago, Illinois.
- 2) College of Osteopathic Medicine and Surgery, Des Moines, Iowa.
- 3) Kansas City College of Osteopathy and Surgery, Kansas City, Missouri.
- 4) Kirksville College of Osteopathy and Surgery, Kirksville, Missouri.
- 5) Philadelphia College of Osteopathy, Philadelphia, Pennsylvania.

A sixth osteopathic college, the Michigan College of Osteopathic Medicine in Pontiac, admitted its first class in the fall of 1969.

The pre-professional requirements under the present legislation for a person wishing to qualify for registration as an osteopath in Ontario stipulate that the applicant must hold an Ontario secondary school graduation diploma, or an equivalent certificate, and must have completed at least two years of university or college training, including courses in physics, organic chemistry, biology and

⁷Board of Directors of Osteopathy, reply to Questionnaire "A", Committee on the Healing Arts.

⁸*Drugless Practitioners in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

English.⁹ These standards are complementary to those of the American Osteopathic Association, which is responsible for accreditation and evaluation of osteopathic schools in the United States. They have been in effect only long enough to have influenced the pre-professional education of a small number of the osteopaths practising in Ontario. Only seven Ontario osteopaths in our study had obtained some university training, and two had obtained a Bachelor's degree prior to entering their professional school.

Regulation 123 under the Drugless Practitioners Act states that an applicant for registration must have attended an osteopathic college which has a four-year course of instruction, consisting of the minimum of 5,000 hours, covering the following subjects:

Anatomy	Obstetrics and gynaecology
Gross anatomy	Principles, practice and
Dissection	technique of osteopathy
Embryology	Neurology
Histology	Psychiatry
Physiology	Psychology
Biochemistry	Paediatrics
Pharmacology	Dermatology and syphilology
Comparative therapeutics	Therapeutics
Materia media	Tropical medicine
Toxicology	Medical jurisprudence
Pathology	Surgery
Public health and preventive medicine	General surgery
Hygiene	Orthopaedic surgery
Sanitation	Urology
Bacteriology	Ophthalmology
Parasitology	Radiology
Immunology	Anaesthesiology
	Otorhinolaryngology

The course of instruction at the five accredited osteopathic colleges consists essentially of two years of basic science courses followed by two years of clinical experience. The total hours of lectures, laboratory work and practical experience among these five osteopathic colleges range between 5,686 hours at the Chicago School and 6,720 hours at the Kirksville College. The academic year consists of thirty-six weeks during the first three years and forty-eight to fifty-two weeks in the fourth year.

As part of their clinical experience, students observe, examine, diagnose and treat patients under the direction and supervision of staff members. Almost all graduates serve a one-year rotating internship after completing the four-year course. This internship is taken in one of eighty-eight hospitals approved by the

⁹R.R.O. 1960, Reg. 123, s. 14.

American Osteopathic Association. In 1967 twenty-five jurisdictions in the United States required an internship of one or more years.¹⁰ Students are rotated through the various hospital departments, including medicine, surgery, radiology and psychiatry.

A large majority (80 per cent or more) of the faculty members at osteopathic colleges are osteopathic physicians. There are very few physicians teaching at osteopathic schools; on the average physicians would make up 3 per cent of the total faculty. The remaining faculty members come from a variety of disciplines, and hold Bachelor's, Master's or Ph.D. degrees.

It is difficult to say how the relationship between osteopaths and physicians in the United States will develop in the near future. On the one hand, the osteopathic profession has reported increasing federal and state support of expansion of osteopathic educational and treatment facilities. In 1968-1969, nearly eleven million dollars was granted from these sources for the improvement of osteopathic college facilities and teaching staff.¹¹ Enrolment figures in the five colleges have increased from 1,594 in 1963 to 1,920 in 1969.¹² On the other hand, the medical profession in the United States has recently made several attempts at amalgamating the two professions of osteopathy and medicine, either by converting schools of osteopathy to schools of medicine or by establishing means by which osteopathic students may be transferred into medical schools and osteopathic graduates be appointed to medical internship and residency programs in hospitals.¹³ In 1962, 2,400 osteopaths joined the ranks of physicians when the College of Osteopathic Physicians and Surgeons in California was converted into the California College of Medicine.

In view of these events taking place in the United States and of the fact that there is no evidence of any increasing demand for osteopathic services in Ontario, the Committee deems it unwise to contemplate any expenditure of public funds towards the establishment of a school of osteopathy in Ontario. Furthermore, we are opposed to the introduction of educational programs for osteopaths because we do not wish to see in Ontario what has developed in the United States: the coexistence of two types of medical practitioners, the osteopathic physician and the medical doctor, licensed under separate legislation to carry out similar functions.

¹⁰Lawrence W. Mills, *The Osteopathic Profession and Its Colleges*, American Osteopathic Association, Chicago, 1967, p. 5.

¹¹Lawrence W. Mills, Director, Office of Education, American Osteopathic Association, in a letter to the Past President of the Ontario Osteopathic Association, June 10, 1969, and communicated to this Committee by A. Victor DeJardine, Immediate Past President, Ontario Osteopathic Association.

¹²Lawrence W. Mills, in a letter to the Medical-Educational Director of the Flint Osteopathic Hospital, Michigan, June 9, 1969, and communicated to this Committee.

¹³John C. Nunemaker, M.D., "Osteopathy and Medicine: Graduate Education", *American Medical Association Journal*, Vol. 209, No. 1, July 7, 1969.

Scope of Practice

The conditions commonly treated by osteopaths vary according to the particular jurisdiction in which they practise. As previously mentioned, osteopaths in the United States are legally permitted to practise the full range of medicine in forty-two states and the District of Columbia. In jurisdictions such as Ontario, where the osteopath's scope of practice is restricted to certain limited procedures, the type of conditions they treat are accordingly restricted. In effect, osteopaths in Ontario are permitted to apply only that part of their training which is not generally used in medical practice. Section 4 of the Ontario Drugless Practitioners Act prohibits osteopaths from prescribing and administering drugs internally or externally, using anaesthetics for any purpose, or practising surgery or midwifery. These prohibitions leave only manipulation of the musculoskeletal system as the main therapeutic procedure available to osteopaths.

In the United States, 70 per cent of the graduates of osteopathic colleges practise as general practitioners in the forty-two states which permit osteopaths the same rights and privileges as physicians; the remaining 30 per cent practise as specialists. It has been estimated that osteopaths now provide health care for between 8 and 10 per cent of the population of the United States.¹⁴ The Committee's study of drugless practitioners indicated that over one-half (54 per cent) of osteopaths in Ontario have one-third of their patients consulting them first for most of their health problems: 21 per cent reported about one-half of their patients; and 26 per cent reported that three-fourths or more of their patients first consult them for their health problems.¹⁵

The Committee's survey indicates that all but one of the Ontario osteopaths claim that the general physical conditions which they treat most frequently are musculoskeletal conditions, particularly lower back problems. Osteopaths reported that two-thirds to three-quarters of their patients have symptoms related to the back. One osteopath mentioned that he most often treats some type of neurological problem, such as sciatica or neuritis. These findings correspond with those of D. L. Mills' study for the Hall Commission, which showed that the general condition most often treated by osteopaths is a musculoskeletal condition, such as a disorder in the lower or upper spine, or in one of the limbs of the body.¹⁶ The next most commonly treated condition is a neurological problem, such as headache, neuritis or sciatica. Psychological problems, such as nervousness, tension and depression, are the third most commonly treated conditions.

Our study reported that "As an adjunct to manipulation some osteopaths employ mechanical or electrical thermal equipment, such as traction devices or infra-red lamps."¹⁷ Mills' study also noted that most osteopaths suggest the fol-

¹⁴Ontario Osteopathic Association, Brief to the Committee on the Healing Arts, 1966, p. 23.

¹⁵*Drugless Practitioners in Ontario, op. cit.*

¹⁶D. L. Mills, *Study of Chiropractors, Osteopaths and Naturopaths in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1966, pp. 173-175.

¹⁷*Drugless Practitioners in Ontario, op. cit.*

lowing types of therapy in treatment for one-third or fewer of their patients: a vitamin regimen, a dietary program, prescription drugs (on referral), non-prescription drugs, a program of exercise, and psychological counselling.¹⁸

In Ontario an osteopath gives treatment either in his office or frequently in a patient's home, but not in a hospital setting. Most osteopaths (forty-one of fifty practising) practise alone, while eight practise with one other osteopath. Thirty-seven report that they have no clinical assistants, seven have one assistant, and four have two or more assistants.¹⁹

The diagnostic and therapeutic equipment used by osteopaths is not unique to their profession, but is in many respects similar to that used by physicians, chiropractors and physiotherapists. With reference to laboratory tests, such as urine and blood analysis, seven reported that they make no such tests, while of the other forty-two who utilize laboratory tests, almost 50 per cent have this work done outside their offices. Only seven of them do all their own laboratory work. Most osteopaths (forty-five) make use of x-rays for diagnostic purposes, but they do so for only a small proportion of their patients (generally about 10 per cent). Almost all osteopaths have their x-ray work done in laboratories outside their offices, because of the present legal limitations on their practice.²⁰ While hospitals do not give x-ray plates to chiropractors, some have no such reservations about osteopaths.

Osteopaths are, however, denied the use of provincial laboratories and hospital laboratories in Ontario. Some are able to have laboratory work performed in private laboratories, while others must refer their patients to a physician in order to have laboratory work completed. The Committee does not think the limitations placed on osteopaths on the use of private laboratories are justified, and has recommended that osteopaths be permitted to send specimens to licensed laboratories for testing. (See Chapter 19, Recommendation 272.)

It is apparent that the small number of osteopaths in Ontario now perform sharply limited functions and play a relatively small role in the provision of health care. It is also apparent that, were these restrictions to remain unchanged, the number of osteopaths in Ontario would continue to decline. It is highly unlikely that recent graduates from the United States will be attracted to enter practice here while they are able to enjoy the legal and professional status of physicians in most parts of the United States. The osteopathic profession in Ontario has made several attempts to expand the scope of their practice, but their efforts have not been successful. This issue has been the subject of two studies carried out by the College of Physicians and Surgeons of Ontario in the past ten years. The study in 1958 maintained that osteopathy contained elements of "dog-

¹⁸D. L. Mills, *op. cit.*, p. 184-195.

¹⁹*Drugless Practitioners in Ontario, op. cit.*

²⁰*Ibid.*

matism and cultism" and was highly critical of the educational standards of osteopaths.²¹ The more recent study, made in 1964, was less critical, but concluded that American schools of osteopathy compare unfavourably with the Canadian medical schools and that graduates from American schools of osteopathy should not be given enabling certificates by the College of Physicians and Surgeons of Ontario. The investigating team of the College based their decision on the evidence that osteopathic colleges were 1) unaffiliated with multi-faculty universities; 2) insulated from the mainstream of medical progress and teaching; 3) deficient in the teaching of the basic sciences; 4) not in possession of sufficient practical clinical training and library facilities; and 5) unable to attract teachers of the highest calibre because of inadequate budgets.²²

The Committee notes, however, that the conclusions reached by other authorities which have also studied osteopathy, as well as the events which have occurred in recent years, throw a different light on the question. We have already referred to the recent steps taken by the American Medical Association's House of Delegates to absorb osteopathy into medicine. There can be no doubt that osteopathy has gained increasing recognition and acceptance in the United States. In Quebec, the Report of the Royal Commission on Chiropraxy and Osteopathy (the Lacroix Report) in 1965, and the subsequent Quebec Commission of Inquiry on Health and Welfare, 1967, were both sympathetic to the claims of the osteopaths. The latter body recommended that the College of Physicians and Surgeons in Quebec be charged with the responsibility of regulating the practice of osteopaths, so that "osteopathy then would become a field of medicine on the same footing as all other branches of this science".²³ In November 1969, the College of Physicians and Surgeons of Quebec announced that the College would be willing to grant licences to some Quebec osteopaths for the full range of medical practice upon review of their individual files. Those osteopaths who are accepted will be considered full members of the College, enjoying all the privileges, rights and obligations usually granted by the Quebec Medical Law.²⁴

We have heard no evidence to suggest that Ontario osteopaths present any danger to the public. Indeed we are persuaded that manipulative therapy is of positive benefit to some patients suffering from certain conditions, particularly conditions related to the back and the musculoskeletal system. Recent graduates of some schools of osteopathy appear to have achieved educational levels and

²¹W. H. Noble, Q.C., "A Study of Osteopathy and Chiropractic", a study prepared for the Council of the College of Physicians and Surgeons of Ontario, December, 1958.

²²College of Physicians and Surgeons of Ontario, *Report on the Study by the Council's Special Committee on the Question of Registering Osteopaths under the Medical Act of Ontario*, 1964, pp. 14-16.

²³Report of the Commission of Inquiry on Health and Social Welfare, Queen's Printer, Quebec City, 1967, p. 67.

²⁴Augustin Roy, M.D., Registrar, College of Physicians and Surgeons of Quebec, letter to Hon. Jean-Paul Cloutier, Minister of Health and Social Welfare, Quebec, and the Committee on the Healing Arts, November 10, 1969.

skills similar or comparable to those attained by graduates of certain medical schools. We believe that osteopathic services should continue to be available to the public of this province.

The controversial questions concerning the capabilities and role of osteopaths in the health care system are matters which should be kept under continuing review by the Ontario Council of Health. The attitude of the College of Physicians and Surgeons of Ontario, which favours the continuation of the present restrictions on osteopathic practice, is based on an assessment of osteopathic education made several years ago. We have evidence that improvements are being made in osteopathic education; thus in some osteopathic schools, the quality of education may be as good as that in some schools of medicine. Therefore, it may be that the time has come, or will come in the near future, when it can be said objectively that the quality of education obtained by an osteopath in the United States is equivalent to the quality of education obtained by physicians in the United States whose qualifications the College of Physicians and Surgeons of Ontario accepts. At that time, those osteopaths should be treated in the same manner as American physicians for purposes of medical licensure in Ontario.* We do not believe, however, that there should be any separate classification under which osteopaths would practise as osteopaths but with the privilege also of practising the full range of medicine; in other words, we do not wish to see the American system of licensing osteopaths applied in Ontario.

We believe, therefore, that the Department of Health should take the initiative in approaching the College of Physicians and Surgeons of Ontario to see if some arrangements could be made whereby individual osteopaths with proper qualifications might be licensed by the College as medical practitioners, provided that the osteopath had graduated from a recognized osteopathic college, had passed the MCC examinations and, if necessary, had completed a year's appointment in an approved hospital program in Ontario.

We also wish to emphasize that when such time arrives that qualified osteopaths may become eligible for medical licensure, those osteopaths who do not meet the licensing requirements should remain restricted to the limited range of practice now permitted in Ontario. We believe that because of the time elapsed since they graduated, most of the osteopaths presently practising in Ontario would fall under this category.

As long as there are osteopaths in Ontario providing the present limited range of services, we believe that changes should be made in some of the regulations covering this discipline. The remainder of our observations and recommendations in this chapter therefore apply to osteopathy as now practised in the province.

The Drugless Practitioners Act in its present form does not provide satisfactory regulatory arrangements for osteopaths. It establishes five categories of drugless

*See minority opinion, pp. 532-533.

practitioners: naturopaths, osteopaths, chiropractors, physiotherapists and masseurs. And it permits a practitioner to be registered under more than one category. In other words, it is possible for a registrant who is barred from practice under one category for a violation of the Act to continue his practice because he is also registered under a second category. In Chapters 21 and 22 following, we propose certain changes in the law relating to drugless practitioners. Here it will suffice to say that we regard the existing Act as unsatisfactory, and that new legislation is required for the regulation of the practice of osteopathy.

Osteopaths in Ontario have always been denied the privilege of admitting patients to hospitals or treating patients in hospitals. In view of the history of osteopathic practice in Ontario and the resulting small group of practitioners remaining in this province, the Committee has concluded that osteopaths should not be granted any extensions to their scope of practice or formal privileges, in or out of hospitals. No demonstrated need for such extension of practising rights appears to exist, and none seems warranted under existing circumstances.

In general, the osteopaths in the province have a congenial relationship with many individual physicians in communities, and it is primarily on the political or organizational level that friction between the two groups occurs. A significant number of Ontario osteopaths report that they do receive some referrals from physicians, the cases referred being typically those which require manipulative treatment of the spine. However, the average number of referred patients seen by the twenty-nine osteopaths who do receive medical referrals is only one to three per month. Only ten of the osteopaths reported that they refer patients to, and receive referrals from, non-medical practitioners, such as podiatrists and optometrists.

The Ontario Osteopathic Association sets a suggested fee schedule for its membership which is reviewed yearly, although practitioners are not compelled to accept this guide.

Treatment performed by osteopaths is covered by a few private insurance carriers, but not under the Ontario Health Services Insurance Plan. The Committee is not of the opinion that all osteopathic services should be insured under the Ontario Plan. We do believe, however, that certain physical conditions which may be treated appropriately and effectively by osteopathic manipulation, particularly conditions involving the back, should be covered by publicly financed health insurance.

Recommendation:

- 274** That manipulative services which osteopaths presently perform, and which would be covered by OHSIP if performed by a physician or physiotherapist, should be covered by OHSIP if provided by an osteopath.

Regulation

The practice of osteopathy in Ontario is regulated by the Drugless Practitioners Act,²⁵ which authorizes the formation of the Board of Directors of Osteopathy. The latter is composed of not fewer than three and not more than five members who are appointed by the Lieutenant Governor in Council for a two-year renewable term. Since 1952, nominees to the Board have been recommended by the Ontario Osteopathic Association to the Minister of Health, although this practice is not specified in the Act. In addition, although again not specified by the Act, all members of the Board are osteopaths registered under the Act.

The Board consists of a chairman, a vice-chairman, a secretary-treasurer, and two members.²⁶ All administrative work is conducted on a voluntary basis by the members of the Board, with the exception of the secretary-treasurer, who is paid a nominal salary. As well, a Special Consultant from the Ontario Osteopathic Association works with the Board. The Board derives its income from a registration fee of forty dollars, a renewal fee of twenty-five dollars and an examination fee which does not exceed fifty dollars and which is calculated on the basis of ten dollars for each subject examined, and twenty dollars for each subject at a supplemental examination.

The Board's responsibilities include: 1) specifying requirements for registration and registering practitioners; 2) prescribing the discipline and control of practitioners and investigating misconduct; and 3) prescribing standards for the training of osteopaths.

A person must be licensed by the Board in order to practise osteopathy in Ontario. The requirements for a licence, which have been specified by the Board in its regulations, stipulate that a persons must be of good moral character and at least twenty-one years of age, must have paid the prescribed registration fee, and must provide character references. An applicant must also pass an examination which covers the following subjects:

- 1) Anatomy and applied anatomy, including histology and embryology.
- 2) Physiology, including physiological chemistry.
- 3) Pathology and bacteriology, including parasitology, immunology, public health and preventive medicine.
- 4) Surgery, including surgical specialties.
- 5) Obstetrics, gynaecology and paediatrics.
- 6) Neurology, psychology and psychiatry.
- 7) Osteopathic medicine, including principles therapeutics, pharmacology, materia medica and jurisprudence.

²⁵R.R.O. 1960, Reg. 123 made under the Drugless Practitioners Act, R.S.O. 1960, c. 114.

²⁶Information about the structure of the Board is drawn from the Board of Directors of Osteopathy of Ontario, reply to Questionnaire "A", Committee on the Healing Arts.

The examination is conducted at least once a year, as required, and consists of written, oral and practical parts. To qualify as a candidate to write this examination, a person must have an Ontario secondary school graduation diploma or an equivalent certificate as determined by the Ontario Minister of Education. Also, the candidate must have completed at least two years of college or university and have taken courses in physics, organic and inorganic chemistry, biology and English (Ontario's grade thirteen can count as one college year). Finally, he must have graduated from an approved college of osteopathy. The Ontario Board does not accredit any osteopathic programs, but accepts the decisions regarding accreditation of the Bureau of Professional Education of the American Osteopathic Association. It is possible for a person who has been registered in a jurisdiction outside of Ontario which has regulations similar to that of Ontario to attain registration as an osteopath without writing the Board's examination.

As mentioned earlier, one of the major functions of the Board of Directors of Osteopathy is to oversee the professional conduct of licensed practitioners and to discipline osteopaths for misconduct. The regulations state that "the Board may, after a hearing, suspend or cancel the registration of any person found to be guilty of misconduct or to have been ignorant or incompetent".²⁷ There is little evidence of misconduct among osteopaths. In the ten-year period 1957-1967, only three complaints against osteopaths were placed with the Board.²⁸ The first complaint was lodged by the College of Physicians and Surgeons against an osteopath who had used the title "Doctor" on his stationery; the second complaint was made by a private citizen that an osteopath was distributing announcement cards in mailboxes; and the third involved an osteopath who the Board of Regents of Chiropraxy claimed was practising chiropody.

We have recommended above that the regulation of osteopaths be removed from the Drugless Practitioners Act and that separate legislation be introduced. The Health Disciplines Regulation Board, acting on the advice of a Division on Osteopathy, should assume the regulatory functions for this discipline. Except for Doctors of Osteopathy, who might at some future date be licensed to practise medicine by the College of Physicians and Surgeons, we propose no change in the existing prohibition against osteopaths using the title "Doctor" (see Chapter 25).

Recommendations:

- 275** That the present Drugless Practitioners Act be repealed and new legislation enacted to regulate the practice of osteopathy, and to provide for the licensing of osteopaths under the jurisdiction of the Health Disciplines Regulation Board.
- 276** That the scope of practice for osteopaths licensed by the Health Disciplines Regulation Board should not be extended beyond that which is presently permitted osteopaths under the Drugless Practitioners Act.

²⁷R.R.O. 1960, Reg. 123, s. 8 (1).

²⁸Information obtained from the records of the Board of Directors of Osteopathy.

- 277** That osteopaths licensed by the Health Disciplines Regulation Board continue to be prohibited by law from using the title "Doctor", with or without a qualification.

The Voluntary Association

The Ontario Osteopathic Association was founded in 1901 and has been a divisional society of the American Osteopathic Association since that time. It is also affiliated with the Canadian Osteopathic Association.

Membership in the Association is voluntary, and it is open to anyone who is a graduate of an approved osteopathic college and is licensed to practise osteopathic medicine in Ontario. Members must pay dues of thirty dollars yearly. Sixty-four per cent of the licensed osteopaths in Ontario are members of the Association.²⁹

The objectives of the Association, as specified in Article III of the Association's constitution, are the same as those of the American Osteopathic Association: to promote the public health; to encourage scientific research; to maintain and improve high standards of medical education in osteopathic colleges; and further to promote the welfare of osteopathy and of its practitioners in the province of Ontario.

The Association is administered by a Board of Directors which consists of a president, president-elect, immediate past president, secretary, treasurer, four other Association members plus an osteopath appointed by the licensing board.

The Association's major activity is its annual meeting, at which information is exchanged about clinical or research topics or other matters related to osteopathy.

²⁹*Drugless Practitioners in Ontario, op. cit.*

Chapter 21 Chiropractors

Few groups within the healing arts have presented so much difficulty to makers of public policy as the chiropractors. No scientific inquiry and no previous Royal Commission or study has been successful in arriving at satisfactory answers to the problems which these practitioners present. For example, the Royal Commission on Health Services (the Hall Commission) decided to defer to the findings of a Commission of Inquiry conducted by a Justice of the Superior Court of Quebec, the Honourable Mr. Justice G. Lacroix, on osteopathy and chiropractic in the Province of Quebec, and thus the Hall Commission made no formal recommendations concerning the merits of chiropractic or osteopathy. Similarly, in Ontario the McGillivray Report on the Workmen's Compensation Board deferred to the Committee on the Healing Arts and declined to make any recommendations on either field of practice. Regarding the recommendations of the Honourable Mr. Justice G. Lacroix, in the *Report of the Royal Commission on Chiropraxy and Osteopathy*, 1965, on the basis of our inquiries we believe that the Lacroix recommendations are inappropriate in the context of the provision of health care services in Ontario. We do, however, agree with his conclusion that "the technique of manipulation used by chiropractors is to be retained, because it is effective and can produce beneficial results in cases where correctly indicated".¹

With full awareness that there are no utopian solutions, we propose to review the existing situation, examine the practice of chiropractic in Ontario, and make recommendations designed to clarify the role of the chiropractor in the health care system.

Historical Origins

The Canadian Chiropractic Association has defined chiropractic as follows:

The philosophy, science and art of locating, correcting and adjusting the interference with nerve transmission and expression in the spinal column and other articulations without the use of drugs or surgery.

The science of chiropractic deals with the relationship between the articulations of the human body, especially the vertebral column, and the nervous system and the role of these relationships in the restoration and maintenance of health.

The philosophy of chiropractic is based upon the premise that disease or abnormal function is frequently caused by interference with nerve transmission and expression, due to deviation from their normal position, of the bony segments of the body, especially the vertebral column. The practice of chiropractic consists of the location and correction of misalignments

¹*Report of the Royal Commission on Chiropraxy and Osteopathy* (The Honourable Mr. Justice Gerard Lacroix, Commissioner), Vol. I, Queen's Printer, Quebec City, 1965, p. 75, cited hereafter as Lacroix Report.

causing any interference with normal nerve transmission and expression, for the restoration and maintenance of health, without the use of drugs or surgery.²

Chiropractic was first established in 1895 in the United States by Daniel David Palmer, the father of the movement. It is alleged that he restored the hearing of a man by means of a spinal adjustment. Palmer proceeded to develop a therapeutic technique based on his discovery. The theory assumed that anatomical faults caused functional disturbances in the body. Palmer believed that minor spinal displacements — or “subluxations”, as chiropractors later began to call them, implying “less than a dislocation” — caused nerve irritation, which in turn led to disturbances of the nervous system, and eventually to illness. The mistake orthodoxy was making, Palmer asserted, was trying to treat disorders without realizing whence they came — that is, from the spinal column.³ Theoretically, by a careful examination of the spine and frequently assisted by x-rays, the chiropractor finds the joint and nerve trouble area. By manipulative adjustments he makes sufficient correction to the individual faulty joint, or the spine as a whole, to allow the nerves to function freely. In this way, chiropractors believe that the body’s own resources are enabled to restore normal healthy function to previously affected parts of the body.

Palmer established the first chiropractic school in Davenport, Iowa in 1897. Today there are eleven chiropractic colleges in the United States that are recognized by the American Chiropractic Association. There are two major schools of thought which divide them. The “straight” or more conservative school advocates the use of only the hands in eliminating nerve interference in the spinal column. Of the eleven chiropractic colleges, three advocate this school of thought and are affiliated with the International Chiropractic Association. The remaining eight colleges advocate a more eclectic school of thought, the “mixed”, which uses other methods of treatment such as light, heat, electricity, vitamins and some drugs. These colleges are affiliated with the American Chiropractic Association.⁴

Ontario has been an important centre for the chiropractic profession in Canada ever since the first chiropractor came to Canada and settled in this province in about 1902. The only chiropractic college in Canada, the Canadian Memorial Chiropractic College, founded in 1945, is located in Toronto, as were three other schools (the Robbins, Ontario and Toronto Chiropractic Colleges), which were in operation between 1908 and 1928. In addition, the Canadian Chiropractic Association has its headquarters in Toronto, and nearly one-half of Canadian chiropractors practise in Ontario.⁵

²Canadian Chiropractic Association, reply to Questionnaire “B”, Committee on the Healing Arts.

³Brian Inglis, *Fringe Medicine*, Faber and Faber, London, 1964, p. 103.

⁴The information on the origin of chiropractic is primarily from Elton Rayack, *Professional Power and American Medicine*, World Publishing Co., Cleveland and New York, 1967, pp. 253-258.

⁵Historical material on chiropractic in Ontario taken from Board of Directors of Chiropractic, Brief to the Committee on the Healing Arts, 1967, pp. 1-8; and A. E. Homewood, “Chiropractic”, *University of Toronto Medical Journal*, 1961, pp. 165-173.

Manpower

The number of chiropractors who practised in Ontario in the early decades of this century is not recorded. At the time of the First World War, there were about sixty-seven chiropractors in the province, and in 1930 and 1940 there were 354 and 389 chiropractors respectively registered with the Board of Regents under the Drugless Practitioners Act. Information is not available on how many of these registrants resided outside the province.

In 1950 there were 360 chiropractors registered and practising in the province, with an additional 138 registrants located outside the province. The number of chiropractors in Ontario increased markedly during the 1950's, no doubt because of the establishment of a chiropractic college in the province in 1945 and the large enrolment of veterans in the college following World War II. The number of chiropractors in Ontario increased by almost 200 between 1950 and 1960, when there were 556 registered chiropractors, with an additional seventy-three residing outside the province. Since 1960 there has been a slight decline in the number of registered chiropractors residing in Ontario, as can be seen from the following figures, which show the number of registrants for each year: 1961—564; 1962—550; 1963—548; 1964—526; 1965—536; 1966—527; 1967—532; and 1968—532. There were approximately 23,000 chiropractors practising in the United States in 1965.⁶

Chiropractors practise in cities of varying sizes, but have a slight preference for cities under 100,000 population (see Tables 21.1 and 21.2).

TABLE 21.1
Distribution of Registered Chiropractors by Size of Community,
Ontario, 1966

Size of community	Registered chiropractors		Population	
	No.	%	No. (000's)	%
All Ontario	528	100.0	6,961	100.0
Metropolitan	241	45.6	3,554	51.0
Pop. 30,000-100,000	88	16.7	1,024	14.7
Pop. 10,000-30,000	65	12.3	458	6.5
Pop. under 10,000	134	25.4	1,925	27.8

SOURCE: R. D. Fraser, *Selected Economic Aspects of the Health Care Sector in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Table A227, p. 420.

⁶*Drugless Practitioners in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967. For 1968 figures: Communication to the Committee on the Healing Arts, Board of Directors of Chiropractic, July 1969.

TABLE 21.2
**Graduates of the Canadian Memorial College of Chiropractic,
 1949-1968, by Place of Origin**

Province or country	Cumulative total	Percentage
British Columbia	106	12.4
Alberta	35	4.1
Saskatchewan	63	7.3
Manitoba	26	3.0
Ontario	477	55.7
Quebec	46	5.4
Maritimes	15	1.7
U.S.	40	4.7
Other countries	49	5.7
Total	857	100.0

SOURCE: Canadian Chiropractic Association, Brief to the Committee on the Healing Arts, 1967 and information supplied directly.

Almost all chiropractors in Ontario (95 per cent) are male.⁷ The age distribution of chiropractors in Ontario in 1962 and 1967 is given in Table 21.3.

TABLE 21.3
Percentage Distribution of Chiropractors in Ontario, by Age, 1962 and 1967

Age	Percentage in age group	
	1962	1967
29 or younger	18	10
30 to 39	39	35
40 to 49	24	33
50 to 59	6	11
60 to 69	9	7
70 or over	4	4

SOURCE: The 1967 figures are from *Drugless Practitioners in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967; the 1962 figures are from D. L. Mills, *Study of Chiropractors, Osteopaths and Naturopaths in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 78.

The slight decrease shown here in the proportion of chiropractors in the younger age categories, and a corresponding increase in the middle age categories, indicate that recently the profession may not have been recruiting proportionately as many

⁷*Drugless Practitioners in Ontario*, op. cit.

younger men to its ranks as it did five or ten years ago. Most chiropractors in the province (84 per cent) have been in practice twenty years or less, that is, since the end of World War II, when chiropractic education became available in Ontario.⁸

Present Scope of Practice

The Drugless Practitioners Act allows the chiropractor to treat certain conditions by certain methods as set out in section 1 (b) under the definition of "drugless practitioner".

... "drugless practitioner" means a person who practises or advertises or holds himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electro-therapy or by any similar method.⁹

Section 7 states the following prohibitions:

Nothing in this Act or the regulations authorizes a person, not being so expressly authorized under a general or special Act of the Legislature, to prescribe or administer drugs for use internally or externally or to use or direct or prescribe the use of anaesthetics for any purpose whatsoever or to practise surgery or midwifery.¹⁰

Regulations under the Drugless Practitioners Act define the scope of chiropractic practice as follows:

The system of treatment that may be followed by chiropractors is the treatment of persons by the relief of interference with the normal functioning of the nervous system of the body by the adjustment or the manipulation or both of the articulations and the tissues thereof, more especially those of the spinal column and when necessary with the aid of (a) exercise; (b) light; (c) thermotherapy; (d) hydrotherapy; or (e) electrotherapy.¹¹

The Venereal Diseases Prevention Act¹² prevents the chiropractor from treating any venereal disease; the Hypnosis Act¹³ prevents chiropractors from using hypnosis; and the Vital Statistics Act¹⁴ prohibits chiropractors from registering the death of any individual.

Neither chiropractors in Ontario nor chiropractic literature are in agreement over what conditions do respond to chiropractic treatment. The view of the Ontario Chiropractic Association is that its members treat conditions of the spinal

⁸D. L. Mills, *Study of Chiropractors, Osteopaths and Naturopaths in Canada*, Royal Commission on Health Services, Queen's Printer, Ottawa, 1964, p. 75.

⁹R.S.O. 1960, c. 114, s. 1 (b).

¹⁰*Ibid.*, s. 7.

¹¹R.R.O. 1960, Reg. 120, s. 1.

¹²R.S.O. 1960, c. 415, s. 11 (1).

¹³S.O. 1960-61, c. 38, ss. 2 and 3.

¹⁴R.S.O. 1960, c. 419, s. 17 (3).

column or the generic grouping classified as neuro-musculoskeletal in nature or origin. They see many diseases manifested distant from the spine as caused by interference with nerve trunks in or at the spinal column. They view chiropractic as effective in conditions having a neuro-circulatory significance and background. Hence, even though representatives of the Canadian Memorial Chiropractic College state that the College is intended to train "general practitioners" rather than "specialists",¹⁵ the chiropractor actually functions as a specialized health worker who treats mainly neuro-musculoskeletal conditions. There are chiropractors, however, who do claim that most illnesses, whatever their nature, can be helped by chiropractic.¹⁶

Chiropractic in Ontario is practised only in the office of a chiropractor, except on the few occasions that practitioners make house calls. Most chiropractors (81 per cent) practise alone, while 12 per cent practise in a two-person group, and 2 per cent in a group of three or more practitioners. About one-half (52 per cent) report that they employ no nurses or clinical assistants, 34 per cent have one assistant, and 12 per cent have two or more assistants. The number of patients treated by the average chiropractor in an average week has increased from between fifty-six and seventy patients in 1962, to between seventy-one and eighty-five patients in 1967.¹⁷ In projecting this 1967 figure with the number of registrants in Ontario at that time, 532, it is estimated that approximately 38,000-45,000 visits per week are made by chiropractic patients.¹⁸ The majority of chiropractors reported that a certain percentage of their patients consult them first for their health problems. One-third (35 per cent) of the chiropractors reported 10 per cent or fewer of their patients, 40 per cent of the chiropractors reported about one-fourth to one-half of their patients, and 12 per cent of the chiropractors reported that about two-thirds or more of their patients consult them before consulting another practitioner.¹⁹

No study has been conducted in Canada which has surveyed patients who have been treated by chiropractors, but there are certain statistics available which result from a nation-wide year-long study of a scientifically selected sample of households in the United States.²⁰ This study revealed that a mean age for persons attending a chiropractor was forty-five to sixty-four years; more males visited chiropractors than females; approximately the same proportion of people in the

¹⁵Canadian Memorial Chiropractic College, Transcript of the Hearings of the Committee on the Healing Arts, May 29, 1967, p. 3645.

¹⁶Board of Directors of Chiropractic, Transcript of the Hearings of the Committee on the Healing Arts, May 29, 1967, p. 3613.

¹⁷The 1962 figures are taken from D. L. Mills, *op. cit.*, p. 82; the 1967 figures are taken from *Drugless Practitioners in Ontario, op. cit.*

¹⁸*Drugless Practitioners in Ontario, op. cit.*

¹⁹*Ibid.*

²⁰National Center for Health Statistics: Characteristics of Patients of Selected Types of Medical Specialists and Practitioners, Vital and Health Statistics, PHS Pub. No. 1000—Series 10, No. 28, Public Health Service, Washington, D.C., Government Printing Office, May 1966, pp. 37-40.

different income categories saw a chiropractor; and among those seeing a chiropractor, the average number of visits per person was 4.7 per year. It is at least arguable that the factors shaping the demand for chiropractic services is similar in Ontario.

There are thus significant numbers of patients who go to chiropractors and who believe they derive benefit from them. The increased public acceptance of chiropractors is evidenced not only by the number of patients who resort to them for treatment, but by the inclusion of chiropractic in many well-established insurance plans as well. Chiropractic care is provided for by the Workmen's Compensation Board of Ontario, as well as the boards of New Brunswick, Manitoba, Saskatchewan, Alberta and British Columbia. In addition, chiropractic services are covered by Blue Cross plans in Ontario and Alberta, by the government-sponsored Alberta Plan, by Medical Services Association of British Columbia and by United Health Insurance, a subsidiary of Manitoba Medical Services.

During the course of our hearings we were assured by several physicians that certain conditions respond favourably to manipulative therapy. Knowledgeable medical specialists have asserted that manipulation is beneficial to some patients suffering from specific ailments. For example, while distinguishing between chiropractic and manipulative therapy, and while rejecting the philosophy of chiropractic, an orthopaedic surgeon representing the Ontario Medical Association stated that "... manipulation of the spine under certain circumstances produces relief of a certain class of disorders. This is not in dispute. There has been an increasing awareness on the part of the medical profession that this is so. Certain groups of the medical profession have always been aware of this; this is why an orthopaedic surgeon is talking to you."²¹

We have discussed the concepts of "harm" and "safety" related to healing practices in the Introduction to this Report. The Committee has heard no conclusive evidence of significant harm, within the context of the meaning of that phrase as we have used it in the Introduction, resulting from chiropractic treatment. On the other hand, the Lacroix Report has pointed out that several experiments and investigations carried out by physicians indicated that the utility and efficacy of therapy by spinal manipulations in many cases had produced results which purely medical treatment has been unable to attain to the same degree.²²

Thus we have concluded that manipulative therapy is a useful form of treatment, although for a limited number of specific conditions only. We believe that manipulation has merit, and that patients should continue to have manipulative treatment available to them. Nonetheless, we also believe that real problems exist concerning the clarification of the limits of the chiropractor's scope of practice.

²¹Ontario Medical Association, Transcript of the Hearings of the Committee on the Healing Arts, June 29, 1967, p. 5482; for the opinion of a psychiatrist to the same effect, see also pp. 5509 ff.

²²Lacroix Report, Vol. I, *op. cit.*, p. 15.

Chiropractors are generally satisfied with the legally defined scope of their practice. However, in two drafts of a proposed new Chiropractic Act, prepared by the Ontario Chiropractic Association, the first included in Appendix I of the brief of the Board of Directors of Chiropractic to this Committee, and the second submitted subsequently to the Committee in August 1967, the chiropractors suggest that there should be an explicit reference in the legislation to the diagnosis of patients. The Drugless Practitioners Act does not specifically confer upon chiropractors the right to diagnose. Chiropractors, however, maintain that they have always been required to make a diagnosis in order to treat, and this view has been upheld in a decision of the Supreme Court of Ontario.²³ In our view, the present scope of chiropractic practice includes diagnosis. However, the chiropractor's ability to diagnose should be re-examined in the light of the quality of the education or training which he has received.

Education

The Canadian Memorial Chiropractic College in Toronto is the only chiropractic school in Canada. The College was founded in 1945 by the Canadian Association of Chiropractors, which was established in the same year. The Board of Directors of Chiropractic accredits this College on the basis of an annual inspection conducted by one of the members of the Board. The inspector, who uses guidelines established by the American Chiropractic Association, checks on the facilities of the school, course outlines, lectures and examinations, adequacy of course coverage, and the credentials of the faculty.²⁴

As a result of its function as accreditor, the Board of Directors of Chiropractic has a supervisory role over the College, but the degree of its influence is not precisely defined. The senior administrative and policy-making body of the College is the Board of Directors, which is composed of fifteen elected chiropractors, one each from the seven provincial divisions of the Canadian Chiropractic Association, plus eight additional members from the province of Ontario. The four Maritime provinces constitute one division, while each of the remaining six provinces has its own division. In 1966, the College created two new bodies: a Senate, which oversees the academic affairs of the school, and an Administrative Council, which deals with administrative and business affairs. Both bodies are composed of four members of the Board, plus other persons from both within and outside the profession. The senior administrative officers of the College are the president, dean, registrar and administrative officer.

The Board of Directors of Chiropractic accepts the decisions made by the Council on Education of the American Chiropractic Association regarding accredi-

²³*Morrow v. McGillivray*, Gale J., June 28, 1957, noted [1958] O.W.N. 41.

²⁴Board of Directors of Chiropractic, reply to Questionnaire "A", Committee on the Healing Arts; and Board of Directors of Chiropractic. Transcript of the Hearings of the Committee on the Healing Arts, May 29, 1967, pp. 3633-3636.

tation of chiropractic colleges in the United States. Since neither the Ontario nor the American body is a recognized educational accrediting body, their standards may not be sufficiently objective. The American Council requires that the following subjects be included in the minimum course of study which are additional to the subjects required by the Ontario Board: gynaecology, paediatrics, geriatrics, dermatology, physical therapy and orthopaedics.

By regulation,²⁵ the minimum requisite pre-professional education is an Ontario secondary school honour graduation diploma of the general course, or its equivalent, with no specific subject requirements and no specific average needed; only a "pass" is required. The College's calendar states that under certain circumstances an applicant may be admitted even if he is deficient in one or two subjects in the final year of secondary school education.²⁶ The College will also consider applications of mature students (over twenty-five years of age) who are deficient in the admission requirements; but according to the present legislation, these students would not meet the pre-professional educational requirements for registration in Ontario.²⁷ The Council on Education of the American Chiropractic Association now requires that students entering approved schools must have two years or sixty semester hours of university training, which would be equivalent to grade thirteen and one year of university in Ontario. Even with this additional year, it appears that throughout the United States, as well as in Ontario, the academic record of the chiropractic freshman is generally much lower than of the trainees in many other healing disciplines, particularly those in medicine.

The Board of Chiropractic will approve²⁸ a chiropractic school if it offers a course which consists of four years of nine months each with a minimum of 4,200 hours of instruction in the following subjects:

Anatomy, including dissection	Radiology
Physiology	First aid and minor surgery
Chemistry	Psychiatry
Medical jurisprudence	Bacteriology
Pathology	Hygiene and sanitation
Psychology	Obstetrics
Ophthalmology	Clinical training
Otolaryngology	Principles of practice, technique and treatment
Dietetics	
Diagnosis and symptomatology	

²⁵O. Reg. 336/61.

²⁶Canadian Memorial Chiropractic College (Calendar of Studies), 1967-68, p. 27.

²⁷R.R.O. 1960, Reg. 119, s. 16(b).

²⁸R.R.O. 1960, Reg. 119, s. 23(2).

The Canadian Memorial Chiropractic College is the only school which the Board accredits. The program of instruction consists of the following:

Anatomy	738 hours
Bacteriology	252 hours
Chemistry	252 hours
Physiology	306 hours
Pathology	342 hours
Philosophy	144 hours
Technique	432 hours
X-ray	270 hours
*Diagnosis	954 hours
Special Courses	90 hours
Subtotal	3,780 hours (3,564 lecture, 217 laboratory)
Clinic	936 hours
Total	4,716 hours

*(Including orthopaedics, dermatology, gynaecology, obstetrics, psychology, etc.)

Most of the basic science courses are taught during the first two years, while the clinical courses are scheduled largely during the third and fourth years. Beginning in the third year, students receive practical diagnostic and treatment experience in the College's outpatient clinic. Students begin their practical experience by giving treatment to fellow students before they are permitted to treat patients.

At the time of writing, the Committee was informed that the Canadian Memorial Chiropractic College proposes to change its course of studies from four years to five years in 1971-1972. The extended course will be divided into a "Natural Science Year", a "Basic Health Science Year", an "Introductory Clinical Science Year", a "Clinical Science Year", and a "Clinical Application Year".²⁹

On the basis of what we have seen and read, we have concluded that the quality of the courses in the basic sciences at chiropractic colleges are inferior to those of North American medical faculties and other university natural science courses in general. The qualifications of the faculty of the Canadian Memorial Chiropractic College give some indication that the basic science training provided may be adequate to offer a chiropractic student a general background, but it does not prepare him to make a competent differential diagnosis. Lacroix has suggested that the major reason for this may be that chiropractors do not use the basic sciences as a foundation for their therapeutic methods or chiropractic procedure. On the other hand, the course of clinical instruction in manipulative technique or procedure

²⁹Communication from H. J. Vear, Dean, Canadian Memorial Chiropractic College, November 11, 1969.

is of high quality. However, as Lacroix has observed, it is organized in terms of the skill to be acquired in the use of the technique and is not directed towards the knowledge required in differential diagnosis.³⁰

There is little opportunity for chiropractors in Ontario to further their education after graduating from a chiropractic college. There are informal educational programs sponsored by the Ontario Chiropractic Association, and the Canadian Council of Chiropractic. At its annual two-day business and educational convention, the Ontario Association invites speakers who present material on clinical topics. Although the College has not established a regular curriculum for graduate studies, it does periodically sponsor speakers and holds one or two-day seminars on such topics as mental health, spinal mechanics and neurological examination. The *Journal of the Canadian Chiropractic Association* offers chiropractors little opportunity to advance their knowledge through reading articles on clinical or research topics. A content analysis of this journal for a four-year period (1962-1965) reveals that only 12 per cent of the space, exclusive of advertising, is devoted to articles on clinical or research topics. The remaining space is devoted to topics related to the advancement of the profession, such as new legislation bearing on chiropractic.³¹

One of the reasons why so little research has been carried out in chiropractic is probably the lack of available funds; another reason is that, considering the qualifications of the faculties of chiropractic schools, it is unlikely that most faculty members would have the capability to undertake basic research. The Canadian Memorial Chiropractic College had twenty-one faculty members in the 1967-1968 academic year, nineteen of whom had "Doctor of Chiropractic" degrees as their only qualification. Of the two faculty members who did not have chiropractic degrees, one had a Ph.D. degree from the University of Toronto and the other had a Bachelor of Science degree from the University of British Columbia. Many of the faculty members teach only part time and are in private practice in the community.

The Committee is most concerned about the sharply limited qualifications of teachers and quality of instruction at the chiropractic college in Toronto. We have observed also that, in contrast to other disciplines in the healing arts, little change has taken place in the theory or practice of chiropractic during the last fifty years. Unlike osteopathy, which has evolved considerably in its practice and its educational arrangements in recent decades, chiropractic has failed to respond or adapt to twentieth-century changes in scientific knowledge; its theories and practices remain substantially unaltered since the founding of the discipline.

³⁰Lacroix Report, Vol. I, *op. cit.*, pp. 101-102.

³¹*The Drugless Practitioners in Ontario, op. cit.*

The Controversy over Chiropractic

The Conflict with Organized Medicine

We have referred to the controversy over the chiropractor's ability to diagnose, and that controversy necessarily raises broader questions concerning the traditional conflict between chiropractors and organized medicine. This conflict has continued for many decades, not only in Ontario, but throughout North America and in many other jurisdictions as well. The recommendations which this Committee proposes cannot be viewed in a proper perspective until the nature of this conflict is examined.

Organized medicine has been more hostile towards the practice of chiropractic than towards the practice of any other major healing group. Innumerable spokesmen for organized medicine have contended that the practice of chiropractic should be sharply limited or abolished. On the other hand, chiropractors complain that application of their chiropractic techniques has been inhibited by organized medicine; chiropractors allege that they have been the victims of discrimination in the health system and that their techniques have been widely misunderstood. In this area of controversy, it is by no means easy to arrive at a balanced view of the merits of the contradictory arguments.

The College of Physicians and Surgeons of Ontario maintains that chiropractic theory is not valid because it is founded on false premises,³² and it believes that manipulative therapy or any of the services offered by chiropractors should not be given to any patient without a prior differential diagnosis which, they maintain, only a licensed medical practitioner is qualified to conduct. Therefore, the College has proposed to this Committee "that chiropractors be entitled to give the treatments authorized under present legislation (The Drugless Practitioners Act) only following diagnosis of the patient's condition by a duly qualified medical practitioner".³³ However, the College proceeds to qualify this position by urging "that a totally independent study be instituted . . . by a commission of scientists of unimpeachable qualifications and integrity to determine unequivocally whether the claims of chiropractors are valid or whether the position taken by the medical profession in respect to chiropractic is the correct one".³⁴

There are several problems which arise when we consider implementation of the proposals put forward by the College of Physicians and Surgeons. Merely to recommend that chiropractors should practise only on referral from a physician does not seem to us feasible. Unless the education of chiropractors were to undergo significant change, it is clear that most physicians would not refer patients to

³²College of Physicians and Surgeons of Ontario, Brief to the Committee on the Healing Arts, Part 2, 1967, p. 33.

³³*Ibid.*, pp. 34, 35, 43.

³⁴*Ibid.*, p. 35.

chiropractors. Such proposals would have the effect only of driving chiropractors out of the province and depriving patients of chiropractic services, results which are not in the public interest.

The College's proposal that a "scientific" study be carried out also seems to us unfeasible. Implementation presents an insuperable problem. Given the history and scope of the conflict, it would be difficult if not impossible to find "objective" persons to conduct the study who could be both scientifically knowledgeable and sufficiently independent to be mutually acceptable. It is also unlikely that any single study could produce evidence that would be convincing to all parties to the dispute.

The position taken on this subject by medical spokesmen is therefore unacceptable to the Committee, especially when we take into consideration the fact that organized medicine has neither done much to examine the utility of manipulation in a scientific way, nor brought forward real evidence of harm done by chiropractors.

The Search for Solutions

We have already touched on other attempts at solutions in other sources and indicated how limited their help has been to this Committee's efforts. In the *Report of the Royal Commission on Chiropraxy and Osteopathy* in Quebec, Mr. Justice Lacroix's principal solution to the problem of inadequate training for diagnosis was to recommend instituting a hospital internship for chiropractors. The Committee finds this suggestion not only inadequate as a solution to educational deficiencies but, given the traditional antipathies which exist between chiropractors and physicians and given established hospital practices, we believe it totally unfeasible. But neither do we believe that the status quo is satisfactory to chiropractors, to physicians or, most important, to the protection of the public interest.

Indeed we find it has been harmful to the public interest that the controversy between medicine and chiropractic over the merits of manipulative therapy has continued unabated for more than half a century without resolution. It is our belief that public authorities must make concerted efforts to settle this prolonged controversy. It seems to us necessary to establish viable working arrangements whereby the benefits of manipulative therapy now provided by chiropractors are not lost to the public. That this is a difficult task to accomplish, we are fully aware, but the existing situation ought not to be permitted to continue indefinitely. Therefore, in what follows we will outline our views and our proposals relating to the practice of chiropractic in an attempt to suggest alternatives to the passive acceptance of an unsatisfactory status quo.

This Committee has serious reservations concerning chiropractic as it is presently taught and practised. On the basis of the evidence we have seen and the testimony we have heard, we are not persuaded of the validity of the general philosophy and much of the theory of chiropractic. There is a body of basic scientific knowledge related to disease and health care which chiropractors tend to ignore or

take exception to despite the fact that they have not undertaken adequate research on these matters. There is no convincing evidence that subluxation, if it exists, is a significant factor in general disease processes. Therefore, the broad application to patients of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment, based upon a theory involving subluxation, is not justified.

On the other hand, as we have stated above, there does appear to be both a considerable body of medical and lay opinion that there is some value to chiropractic manipulative therapy, particularly for problems involving the lower back, and a substantial number of people who believe that they obtain benefit from manipulative therapy. Hence we repeat that we reject any suggestion that would result in the public being deprived of chiropractic services.

We believe that the problem of chiropractic has become clouded by the insertion of the issue of whether or not the chiropractor can diagnose. The chiropractor's diagnostic capability seems to us very limited at best. We have already indicated that the inadequacies of chiropractic education, coupled with a theory that negates proven causative factors of disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis. It should be noted that these conclusions are essentially in agreement with those of the Report of the Department of Health, Education and Welfare presented to the Congress of the United States, entitled "Independent Practitioners Under Medicare", 1968, which stated that the theory and practice of chiropractic are not grounded upon scientific principles.³⁵ Furthermore, we do not think it necessary that chiropractors should have extensive diagnostic capacity, and we think it would raise false hopes to suggest that problems related to the practice of chiropractic could be solved if chiropractors could perform differential diagnosis. Attempting to teach the chiropractor to diagnose would not solve the problem, because it would require a course of studies even longer than that proposed in the extension of the curriculum for 1971-1972 and, more important, would require a fundamental change in the attitudes and beliefs of chiropractors relating to health and illness.

Thus we do not believe that the chiropractor's lack of ability to diagnose is crucial to the issue before us. Perhaps a limited ability to diagnose problems connected with treatment of conditions of the spinal column is all that may be required of a chiropractor. However, it is desirable that chiropractors not mislead people as to the kinds of illness which might be benefited by manipulation. It is even more desirable that chiropractors should not give treatments which result in physical harm to patients.

Physicians have expressed the fear that chiropractic technique may be employed in cases in which manipulation is contra-indicated. To the extent that we

³⁵"Independent Practitioners Under Medicare: A Report to the Congress", Department of Health, Education and Welfare, Washington, D.C., Wilbur J. Cohen, Secretary, December 1968. However, it should be noted that this material came to our attention only after we had formulated our general view of chiropractic.

are not satisfied that chiropractors can diagnose because of the limitations of their education, there is some justification for this fear. Means must be found to safeguard the public from harm which may be caused by manipulation when it is not correctly indicated, without suppressing the practice of chiropractic.

Because of our philosophy (see Chapter 1) respecting the individual's freedom of choice of practitioner in the context of the legitimate concern of the state for the safety of its citizens, and because of our conviction that chiropractic manipulative technique has value and should be preserved, we think the present situation should not continue. With these considerations in mind, we believe that the best possible solution to the problem is the introduction of certain arrangements by which chiropractic technique could be employed only in cases in which it is appropriate—that is, where there is assurance that a competent opinion had been given that the application of the technique was not contra-indicated by reason of the patient's condition. In proposing our solution to the problem, we have been influenced primarily by the conviction that the present relationships among chiropractors, orthodox medicine, society and government are irrational and should be changed.

For greater certainty, we must repeat our assessment of the existing complex arrangements and underline the shortcomings of the present situation.

Although we are convinced that the theoretical basis of chiropractic is unsound, we are satisfied from our investigations that there is merit and validity in the manipulative technique of chiropractic.

Many people resort to chiropractors, and chiropractic manipulative therapy has an obvious appeal to many members of society.

Chiropractors are not educated within a system that exposes the student to universally accepted scientific thought and, perhaps most important in any truly educational experience, to the questioning of dogma.

The continued supply of these practitioners is not afforded public financial support, notwithstanding that there is validity to their technique and considerable public demand for their services.

The state has already conferred certain recognition on the discipline of chiropractic which would be difficult to withdraw without discharging a very heavy onus to show that chiropractic must be eliminated. Although physicians reject chiropractic and even resort to polemic, the medical profession has not discharged this onus. State recognition is seen not only in the endorsement implicit in the regulation of chiropractic under the *Druggles Practitioners Act*, but also in the chiropractic students' right to receive a scientific education granted by the Province by equating the chiropractic school with the provincial medical schools for the purposes

of entitlement to cadavers under the Anatomy Act.³⁶ And of course the Workmen's Compensation Act³⁷ recognizes chiropractic treatment as a valid method of therapy for the purposes of compensation benefits.

On the other hand, the limitations of the underlying theory of chiropractic, and particularly of their education, mean that there is an ever-present danger that chiropractic treatment will be employed on patients when it is contra-indicated.

It follows that the real problem is to bring about cooperation between medicine and chiropractic, so that chiropractic manipulative techniques will be preserved but not employed where contra-indicated. To bring about such cooperation will by no means be an easy task, but because it is so much in the public interest, it is a task which we sincerely hope will be possible to achieve.

What we propose is that chiropractic education should be brought within the publicly supported and administered system of education for the health disciplines. We see no justification for placing chiropractic education in a university. However, a College of Applied Arts and Technology or other similar highly developed post-secondary educational institution which is already teaching other health personnel, and which has access to appropriate staff and clinical facilities, would be a suitable location.

This educational system should be one in which the student of chiropractic will be exposed to teaching not only by chiropractors who can communicate the technique, but also by scientists including physicians who can teach science and stimulate the questioning of dogma. We recognize that students trained in such a system would not be chiropractors in the sense of those who have been trained in the Canadian Memorial Chiropractic College. They would not, for example, receive the same instruction in chiropractic theory, but instead would be exposed to generally accepted scientific principles of disease. We would expect also that the new program would stress the limitations of manipulative therapy, and the limitations of the practitioner's ability to diagnose. The graduates should be entitled to practise chiropractic in Ontario by virtue of a licence conferred on them by the Health Disciplines Regulation Board (see Chapter 25) through a Chiropractic Division of the Board responsible for the regulation of chiropractic practice.

Members of the public should continue to be free to consult chiropractors directly and without a medical referral, but before chiropractic treatment is commenced, a differential diagnosis by a qualified physician should be required; if manipulative therapy is contra-indicated for the patient's condition, that fact should be made known to the patient by the physician, but no restriction should be placed on the patient's right to resort to chiropractic therapy if he so chooses. It will be recalled that in Chapter 13 (Recommendation 162) we propose a similar

³⁶S.O. 1967, c. 3.

³⁷R.S.O. 1960, c. 437.

arrangement for medical diagnosis prior to therapy being given a patient by clinical psychologists; thus we are not singling out chiropractic treatment as unique in this regard, nor do we intend to restrict unduly the practice of chiropractors, but only to introduce additional safeguards for the good of patients. Ideally, to facilitate such consultation chiropractors should be eligible for inclusion in multidiscipline community health centres (see Chapter 29). Furthermore, although we propose that manipulative services, which chiropractors presently perform and which if performed by another health practitioner would be covered by OHSIP, be covered by OHSIP if provided by a chiropractor; it should be made a condition of insurance payment that evidence be produced that a medical diagnosis had been made. With full awareness of the difficulties inherent in the traditional conflict between medicine and chiropractic, we believe that physicians should develop the habit of referring their patients to chiropractors or osteopaths where manipulative techniques are indicated.

It must be emphasized that our purpose in proposing these changes is to preserve the availability of chiropractic techniques to the public. We are apprehensive about the views expressed at our hearings³⁸ by some spokesmen for the medical profession that in the interests of public safety chiropractic should be practised only upon referral from a physician, and that the traditional attitudes of many physicians are such that cooperation between physicians and chiropractors may not develop, with the result being the demise of chiropractic. Our proposals do indeed place a heavy responsibility on physicians not to interfere with the patient's choice of a practitioner, either directly or indirectly, at the consultation for the required diagnosis which we see as a condition precedent to chiropractic treatment. Indeed physicians should also be expected to participate in the education of chiropractors in their new educational environment.

If it should develop that such a diminution in the demand for chiropractic services occurs that it becomes a reasonable inference that physicians are using the required medical consultation as a means of discouraging patients from resorting to chiropractors where manipulative therapy is not contra-indicated, then legislative changes would have to be considered which would have the effect of removing the requirement of a medical diagnosis. We would charge the Department of Health and the Ontario Council of Health with the responsibility of undertaking a constant surveillance of this matter to see that impediments which hinder the working of these arrangements are not permitted to develop. Of course, any complaint of an interference by a physician in the patient's choice of a chiropractor where chiropractic manipulation is not contra-indicated would be the proper subject of an investigation by the Health Commissioner whose office we propose in Chapter 25 be established.

If in order to preserve the availability of chiropractic technique it should become necessary, by reason of obstruction by medical practitioners in failing to discharge the obligations which our proposal places upon them, to amend our

³⁸College of Physicians and Surgeons of Ontario, Transcript of Hearings of the Committee on the Healing Arts, July 6, 1967, pp. 5874-5890.

proposed arrangement and permit chiropractic treatment even in the absence of a medical diagnosis, with the consequent danger that chiropractic treatment may be employed where it is contra-indicated, then physicians will be forced to realize that they must share a large measure of responsibility for that unfortunate state of affairs.

If it be objected that our proposals are premised upon mutual willingness between chiropractors and physicians to change traditional attitudes towards each other and perceptions of their respective role and status, a premise which is difficult to reconcile with contemporary reality, we make the following responses. First, traditional attitudes concerning the independence of the various health disciplines is rapidly giving way to a realization of the interdependence of the various disciplines. Second, the only apparent alternative to our proposals is simply the maintenance of a status quo which is condemned by most interested parties and which seems to us highly undesirable. Therefore, while we recognize that our proposals cannot be expected to win instant and universal approbation, we believe that nothing but good, or at the very least marked improvement of the existing situation, can result from strenuous attempts by public authorities to implement the scheme which we have outlined. If it should occur despite every effort of the Government of Ontario that our proposals regarding the education of chiropractors cannot be implemented, the education of chiropractors would probably continue in the present Canadian Memorial Chiropractic College. In such an event, however, no public financial support should be given to that College, as we do not believe that the expenditure of public funds can be justified for an educational program regarding some elements of which there is considerable question.

Recommendations:

- 278** That, in order to preserve chiropractic technique, and to bring about cooperation between physicians and chiropractors for the benefit of the public, new arrangements be made for chiropractic education, bringing it within the publicly supported and administered system of education for the health disciplines, locating it in an appropriate College of Applied Arts and Technology or other similar post-secondary educational institution where chiropractic students may receive instruction from physicians and other scientists as well as from chiropractors.*
- 279** That the educational program for chiropractors be so designed as to ensure first, that chiropractic students be made aware of the limitations of manipulative therapy, and second, that chiropractic students not be misled, or be likely to mislead their patients, as to their ability to diagnose.*
- 280** That chiropractors continue to be restricted to the scope of practice allowed by the existing Drugless Practitioners Act.

*See minority opinion, pp. 534-536.

- 281** That the public continue to be free to consult chiropractors directly and without medical referral, but that before chiropractic treatment is commenced a differential diagnosis by a qualified physician be required to ensure that manipulative therapy is not contra-indicated; however, a physician should not in any way prevent a patient from resorting to chiropractic treatment if the patient so desires.*
- 282** That manipulative services which chiropractors presently perform and which if performed by another health practitioner would be covered by OHSIP, be covered by OHSIP if provided by a chiropractor, but that it be a condition of such insurance payment that the patient produce evidence that a medical diagnosis has been made.
- 283** That the Ontario Council of Health and the Department of Health undertake a continuing surveillance of relations between medicine and chiropractic to ensure that physicians do not interfere with the right of patients to seek chiropractic treatment.

In our view the medical profession has a direct responsibility to the public, not only to maintain high standards of practice in its own profession but to assist in raising the standards of practice in other health disciplines. The initial and principal means of assuring high standards of health practices is through the achievement of high quality educational programs. Although in the past the medical profession has displayed a reluctance to permit physicians to participate in the education of non-medical students, this attitude appears to be changing, particularly with the establishment of multidiscipline schools of health sciences. We believe that the participation of physicians in the educational programs for students in related health disciplines including chiropractors is not only desirable but essential. Thus, as we have previously stated in Chapters 8 and 12, physicians should not be inhibited from participating in such programs.

Recommendation:

- 284** That it be declared to be contrary to public policy for medical bodies to attempt, either officially or unofficially, to prevent members of the medical profession from teaching students of other health disciplines including chiropractic and that the medical profession reassess its attitude towards chiropractic, to ensure that physicians do not discriminate against chiropractors and patients of chiropractors, or inhibit physicians from teaching chiropractic students.

The Committee is also concerned that the potential therapeutic benefits of manipulation have been neglected by the medical profession, and we detect in this neglect a direct relationship to the continuing controversy over the practice of chiropractic as well as the efficacy of manipulation therapy.

*See minority opinion, pp. 534-536.

Recommendation:

- 285** That faculties of medicine in Ontario encourage the teaching of manipulative techniques to medical students.

Further Issues

An investigation of the diagnostic and therapeutic devices that chiropractors use in their practice was made for the Royal Commission on Health Services by D. L. Mills. His study revealed that the major diagnostic equipment totalling over one hundred different items, which were mentioned by respondents, was classified under the following six general categories: radiological diagnostic equipment such as x-ray; cardiovascular diagnostic devices such as a stethoscope; neurological diagnostic equipment; chemical analysis diagnostic devices such as urinary diagnostic kit; musculoskeletal diagnostic equipment such as a posture measuring device; and other diagnostic equipment such as an eye, ear and throat kit. Radiological equipment was used by 76 per cent of the chiropractors, and equipment in the stethoscope category was used by 65 per cent, while the percentage of chiropractors using equipment from the four other categories ranged from 20 to 40 per cent.³⁹

To date it has been the policy or practice of hospitals to refuse to make the results of x-rays taken in any hospital available to chiropractors, even when the patient so wishes. The Committee sees this as an example of the medical profession's somewhat unreasonable attitude towards chiropractors, as well as an imposition of undue expense and, more important, an unnecessary exposure to radiation for the patient.

Recommendation:

- 286** That hospitals be required to release x-ray films to chiropractors upon the request of the patient.

At present chiropractors in Ontario do not have hospital privileges. In our view there is nothing, either in the existing situation or in the new arrangements which we have proposed, which would necessitate extension of such privileges.

The Ontario Chiropractic Association establishes a fee schedule which serves as a guide for chiropractors in charging fees for treatment and various diagnostic procedures, but the practitioners are not obliged to follow this schedule. Fifty-two per cent of chiropractors report that two-thirds or more of their patients pay at the time the service is provided, while the other patients either pre-pay or are billed after their treatment. As in the case of other practitioners whose services we have recommended should be covered under publicly financed health insurance, we believe that the chiropractic fee schedule should not be set unilaterally but

³⁹D. L. Mills, *op. cit.*, p. 164.

negotiated by the Ontario Chiropractic Association and the Minister of Health, with the Minister being advised by the proposed Fee Negotiations Advisory Committee (see Chapter 24).

Recommendation:

287 That the fee schedule published by the Ontario Chiropractic Association be a matter of prior negotiation by the Association and the Minister of Health, who would be advised by the proposed Fee Negotiations Advisory Committee.

Regulation

The practice of chiropractic in Ontario is regulated by the Drugless Practitioners Act.⁴⁰ This Act authorizes the formation of the Board of Directors of Chiropractic, which is composed of no less than three and no more than five members who are appointed by the Lieutenant Governor in Council for a two-year term which is renewable. The Board consists of a chairman, a vice-chairman, a secretary-treasurer and two members. Although not required by the Act, all members of the Board are chiropractors registered under the Act.

The Board is responsible for the administration of chiropractic legislation. Its major functions include: specifying requirements for registration and registering practitioners, discipline and control of the profession, prescribing the training standards for chiropractic, and approving the chiropractic schools. The Board functions as a single administrative unit and has no committee structure. It employs one full-time and one part-time person to handle administrative and clerical tasks, and hires an inspector and an investigator on a part-time basis. The Board members work on a voluntary basis. The sources of the Board's income include the initial registration fee of forty dollars, a yearly renewal fee of thirty dollars, an examination fee which does not exceed fifty dollars, as well as the interest earned on cash in the bank.⁴¹

The qualifications for registration as a chiropractor in Ontario are set out in the Board's Regulations under the Drugless Practitioners Act.⁴² They include that an applicant must be of good moral character, at least twenty-one years of age, and be a graduate of an approved chiropractic college. An applicant must pay a registration fee after passing an examination in the following subjects: anatomy, histology, physiology, bacteriology, physiological chemistry, hygiene and sanitation, diagnosis and symptomatology, pathology, and principles of practice, x-ray and treatment. To be eligible to write these examinations, the candidate must hold an Ontario secondary school honour graduation diploma of the general

⁴⁰R.S.O. 1960, c. 114 as amended by S.O. 1961-62, c. 36.

⁴¹Information given here is taken from Board of Directors of Chiropractic, reply to Questionnaire "A", Committee on the Healing Arts.

⁴²R.R.O. 1960, Reg. 119, ss. 3, 14.

course, or an equivalent certificate as determined by the Ontario Minister of Education. Since 1965 it has been possible for any applicant who has passed an examination set by the National Examining Board of the Canadian Chiropractic Association in any of the foregoing subjects to be exempted by the Board of Directors of Chiropractic from taking a further examination in that subject.

A person may be registered in Ontario without examination if he is registered as a chiropractor in a jurisdiction outside the province which has regulations similar to those prescribed by the Ontario Board, or in a jurisdiction with which the Ontario Board has a reciprocal agreement.

The Board is responsible for the discipline of chiropractors. As well as investigating complaints of misconduct of practitioners and the subsequent disposition of the complaint, the Board is also responsible for prosecuting unregistered persons who practise chiropractic. The legislation gives little indication of what types of professional behaviour are inappropriate, except that it specifies that chiropractors may describe themselves only as chiropractors and any public notice or advertising material must first be approved by the Board. There is no routine system of inspection, and an investigator is hired only for the investigation of written complaints. If a complaint cannot be handled by telephone or correspondence, the case is handled at a hearing at which the accused may call witnesses in his behalf and be represented by counsel. A person who practises chiropractic without being registered with the Board of Directors of Chiropractic may be charged with illegal practice, provided that he is not registered under the Drugless Practitioners Act as an osteopath, drugless therapist, physiotherapist or masseur.

In the ten-year period from 1957-1966, 100 complaints were received and noted by the Board. An analysis of these complaints reveals that seven were against individuals who were alleged to be practising chiropractic without being registered, while the other ninety-three were made against registered chiropractors. The types of offence about which the Board received complaints, in the order of frequency included: improper advertising; improper treatment, such as using questionable equipment or procedures, or making questionable claims about treating certain conditions; overcharging or having inappropriate billing methods; using the title "Doctor" and employing unqualified personnel. In the ten years under question, only three practitioners' licences were cancelled, and no suspensions were reported for that period.⁴³ One offence which the Board does not prosecute is the chiropractors' use of the prefix "Doctor", for it considers that these practitioners should have the right to use that title. This situation seems to us unsatisfactory and dangerous. As we have noted in several previous chapters, and as we elaborate in Chapter 25, the Committee is opposed to the indiscriminate use of the term "Doctor" which can be misleading to the public.

⁴³*A Comparative Study of Discipline in the Healing Arts in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

Recommendation:

- 288** That chiropractors continue to be prohibited by law from using the title "Doctor", with or without a qualification.

For the reasons given in Chapter 25, and as we have stated in relation to other disciplines, we believe that the regulation of all health disciplines except the senior professions should be under the jurisdiction of a single Board, the proposed new Health Disciplines Regulation Board. In our view the regulation of chiropractors should be included under this Board. All chiropractors presently registered under the Drugless Practitioners Act would be automatically eligible for licensing by this Board. A Chiropractic Division should be created under the Board to establish and enforce standards of licensure for new practitioners. The Board would also be responsible for the discipline of chiropractors.

Recommendation:

- 289** That the present Drugless Practitioners Act be repealed and new legislation enacted to regulate the practice of chiropractic and to license chiropractors under the jurisdiction of the Health Disciplines Regulation Board through a Division for chiropractors.

Inherent in the present Drugless Practitioners Act, which permits a practitioner dual registration or the right to be registered under more than one category, is the problem of control. In other words, it is possible for a chiropractor to be barred from practice for a violation of the Act, but continue to practise because he is registered under the Act as a naturopath or a drugless therapist as well. With the regulation of chiropractors being placed under the Health Disciplines Regulation Board, the right of chiropractors to be licensed under other classifications in the present Drugless Practitioners Act should be abolished.

Recommendation:

- 290** That those chiropractors choosing to be licensed as chiropractors under the Health Disciplines Regulation Board by virtue of being registered as chiropractors under the Drugless Practitioners Act be prohibited from practising as any other category of practitioner under an authority previously issued by any other board under the Drugless Practitioners Act.

Voluntary Association

The Ontario Chiropractic Association had its beginning in 1929 when it was incorporated under the Corporations Act of Ontario. It became a division of the Canadian Chiropractic Association when the latter was organized under a federal charter in 1953.

Approximately 70 per cent of the chiropractors practising in Ontario are members of the Association. Membership is voluntary and is open to persons who are registered to practise chiropractic in Ontario. Annual membership fees are \$135, of which seventy dollars are retained by the Association, thirty-five dollars are submitted to the Canadian Chiropractic Association and thirty dollars are distributed to the Canadian Memorial Chiropractic College for membership in those organizations. Reduced fees are provided for new graduates of chiropractic colleges during their first two years of practice, and for persons who have practised for forty years or more and are in semi-retired status. There are three major categories of membership: honorary; active; and associate. According to its Constitution, the Association's objectives are to "advance the science of chiropractic and to promote the welfare of those engaged therein". To achieve these objectives the Association has established an administrative structure which consists of a Board of Directors, officers and various committees. The Board of Directors consists of twelve members who are elected at the annual meeting of the Association. Six of the twelve members are elected each year for a two-year term. The Board elects the president, first vice-president, and second vice-president of the Association for a term of one year and may re-elect these officers at the end of the term. The Board appoints the secretary-treasurer and the executive secretary for a three-year term, which may be renewed. One person may be appointed to both of these offices. Appointees are *ex officio* members of the Board without vote. Other elected officials of the Association include three representatives on the National Board of Canadian Chiropractic Association and one representative on the Board of Directors of the Canadian Memorial Chiropractic College.

The president of the Association, with the consent of his Board of Directors, appoints the committees of the Association which are responsible for each of the following: Ethics and Discipline, Insurance Relations, Workmen's Compensation Board, Legislation, Labour Relations and Joint Advisory activities to coordinate the Board of Directors of Chiropractic and the Association. The Association also has committees which are concerned with membership, budget, the annual convention and a newsletter.

There have been eleven district councils set up, under the auspices of the Association, representing different areas of the province. Presidents of these councils serve on an advisory board which meets with the Association's Board at least once a year. These councils provide a means by which chiropractors in a given region can exchange information and ideas, further their education, and sponsor public service projects in collaboration with the provincial and national associations.

Chapter 22 Naturopaths and Natural Hygienists

Naturopaths

Naturopathic Practice

The basic belief of naturopaths is that if the human body is nourished only by the "natural" ingredients that it requires, and if ingredients that are inessential and harmful are excluded from the body as far as possible, illness and disease can be prevented. Naturopaths contend that if disease does strike, the body will ordinarily be able to ward it off by its own unaided efforts, normally without recourse to drugs or surgery.¹ Practising naturopaths generally discount or reject the germ theory of disease and much orthodox medical treatment.

Naturopaths in Ontario are presently permitted to employ four major modes of treatment which are common to the practice of naturopathy throughout the world: corrective nutrition, body mechanics, physiotherapy, and remedial psychology, although the authority for the last mentioned is doubtful. In this connection we refer the interested reader to Chapter 25 for a fuller discussion of the Drugless Practitioners Act as it pertains to naturopathy.

The naturopaths' clientele appears to consist mainly of those who seek an approach to health different from that usually provided by orthodox medicine.²

In 1967 there were seventy-nine practitioners of naturopathy registered with the Board of Directors of Drugless Therapy; of these, seventy were registered also with the Board of Directors of Chiropractic and practised both as chiropractors and naturopaths.³ The average age of naturopaths in Ontario was approximately sixty-five years.⁴ There were only eight naturopaths under forty years of age in Ontario. Only nine of the total registrants were female, and these were registered with both the Drugless Therapy and the Chiropractic Boards. About one-half of the registrants have practised in Ontario for over twenty-five years, and only two persons have registered as naturopaths within the last five years. The naturopaths

¹The Ontario Naturopathic Association, Transcript of the Hearings of the Committee on the Healing Arts, June 14, 1967, pp. 4390-4398.

²The Ontario Naturopathic Association, Supplementary Brief to the Committee on the Healing Arts, 1967, p. 2.

³*Drugless Practitioners in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

⁴*Ibid.*

are concentrated in the large urban areas, with forty-one practising in cities of 100,000 population or larger; seventeen practising in cities of 20,000 to 100,000 population; twelve in cities of 5,000 to 20,000 population; and only eight in cities of fewer than 5,000 people.⁵

Most naturopaths practise alone in offices located in their homes, although some house calls are made. These practitioners use a variety of diagnostic and therapeutic instruments and procedures which have been approved by the Canadian Naturopathic Association. Naturopaths report that they are denied the use of most community health facilities, including provincial laboratories and the diagnostic services of hospitals; those who obtain diagnostic services outside their offices do so mainly through private laboratories.⁶ Their diagnostic procedures include laboratory tests in connection with the analysis of blood, urine, sputum, or fecal specimens; they also use roentgenographic equipment and procedures which include diagnostic x-rays, fluoroscopic examinations and electrocardiography. Included in their therapeutic procedures are decongestive therapy, vitamin and mineral therapy, manipulation techniques and use of packs, compresses, traction equipment and various rehabilitation devices.

The Regulations of the Board of Directors of Drugless Therapy, under the Drugless Practitioners Act, state that a drugless therapist may treat "any ailment, disease, defect or disability of the human body by methods taught in colleges of drugless therapy or naturopathy and approved by the Board". The Board defines the methods taught at approved colleges as follows:

The methods . . . consist of a complete order of natural therapeutics, embracing the use of nature's agencies, processes, and products; and include the application of physiotherapeutical (electrical, mechanical, manual, adjustive, manipulative, orthopaedic [minor surgery]) procedures; emphasizing the treatment of prophylaxis; nutrition, vitamin-mineral, tissue salts; phyto-therapeutics; and psychological (psychotherapeutics — remedial psychology).⁷

Section 7 of the Ontario Drugless Practitioners Act prohibits naturopaths from prescribing and administering drugs internally or externally, using anaesthetics for any purpose, and practising surgery or midwifery. Section II of the Act also states that naturopaths must comply with the requirements of the Public Health Act, the Vaccination Act and the Vital Statistics Act.

Roughly sixty-three of the naturopaths in Ontario make use of a vitamin regimen in their treatment, using it on about one-quarter of their patients. Most naturopaths suggest dietary change to patients, while roughly forty of the naturopaths use botanical medicine (non-prescription). All naturopaths use psychological counselling as a form of therapy for about one-quarter of the total cases treated.⁸

⁵*Ibid.*

⁶*Ibid.*

⁷This statement is to be found on the inside cover of the Regulations of the Board of Drugless Therapy; however, it is not an integral part thereof.

⁸*Drugless Practitioners in Ontario, op. cit.*

Naturopathic treatment is not covered by the Ontario Health Services Insurance Plan. But services of naturopaths are covered by the provincially sponsored health insurance plans in Alberta and British Columbia. Naturopathic services in Ontario are paid for on a fee-for-service basis, and a suggested fee schedule has been drawn up by the Canadian Naturopathic Association as a guide for practitioners.

Most naturopaths claim that they refer patients to another practitioner when they meet a case which is beyond their ability to treat. They refer cases such as malignancies, lacerations, fractures, and acute infectious diseases which require surgery or drugs, and cases which do not respond to the treatment of the naturopath. Most of the naturopaths' patient referrals involve physicians, although some referrals are made to other practitioners such as dentists and chiropodists. On the average naturopaths refer two patients per month to physicians. Very few cases are referred to naturopaths by physicians; however, there are twenty-eight naturopaths who claim that they receive one or two referrals per month, and another twelve said that they receive three or more such referrals.⁹ The types of conditions that are most commonly referred to naturopaths in Ontario are those that require some form of manipulation or physical therapy, such as back pain or muscle strain. Although the naturopaths claim that they refer those cases which are beyond their competence to treat, the Committee is convinced that naturopaths lack the ability to perform a differential diagnosis or identify those cases which require referral. The education of naturopaths is discussed briefly below.

Education

The only naturopathic institution which is accredited by the Canadian Naturopathic Association is the National College of Naturopathic Medicine, located in Oregon. There is no accreditation of naturopathy schools other than by naturopathy organizations or boards, in either Canada or the United States. The minimum requirement for entrance to this college is completion of four years of high school and two years, or sixty semester hours, of university training in an institution that is approved by the Oregon Board of Higher Education.¹⁰

A study was conducted in Utah in 1957 which was to review the licensing provisions and regulation of the healing arts with particular emphasis on the practice of naturopathy. It was to determine as well whether the practice rights of naturopaths should include the use of drugs, minor surgery and the practice of obstetrics. The National College of Naturopathic Medicine in Oregon was visited by a representative of the investigating Committee. The Utah study reported that, except for courses in the basic sciences, most of the training is provided by part-time teachers who are naturopaths in private practice. In the Science Department the maximum qualification of instructors is a Master's degree; this indicates that the quality of training is not high. The study concluded that the scope of

⁹*Ibid.*

¹⁰*Ibid.*

practice of naturopaths should not be extended beyond that presently authorized, unless there is assurance that schools provide adequate training and unless the quality of such training is evaluated by qualified and recognized accreditation agencies;¹¹ these conditions have not been met.

The educational requirements for admission to a college of naturopathy for persons intending to practise naturopathy in Ontario are completion of grade thirteen or its equivalent.¹² In the regulations under the Drugless Practitioners Act,¹³ it is stated that an applicant for registration must be a graduate of a college, but it is not specified that it be a college which teaches drugless therapy or naturopathy. The regulations do stipulate that a college teaching drugless therapy shall not be approved by the Board unless its course of instruction is not less than four years and unless it teaches a minimum course of at least 4,200 fifty-minute hours or its equivalent in the following subjects:¹⁴

Anatomy (including all branches, gross Anatomy, Dissection, etc.)	Principles of practice, technique and treatment
Physiology	Diagnosis
Chemistry	First aid and minor surgery
Medical jurisprudence	Psychiatry
Psychology	Gynaecology
Pathology	Bacteriology
Eye, ear, nose and throat	Hygiene and sanitation
Histology	Symptomatology
Dietetics	Obstetrics

Section 15 of Regulation 121 states, however, that the Board may give approval to a candidate to write the registration examinations "upon proof of the candidate having taken the proper course at any one of the schools or colleges approved by the Board, or upon proof of such other course or courses of instruction, both in professional subjects and in academic or secondary subjects, as in each case is satisfactory to the Board."

Therefore, theoretically, the Board could, if so desired, register a graduate of any institution teaching any discipline as long as the candidate could pass the examinations set by the Board. The Committee has been unable to determine just how much formal training in naturopathy or drugless therapy most registered naturopaths have actually received, but certainly we believe that the educational requirements for licensure in this field are less than satisfactory.

¹¹"A Report to the Utah Legislative Council" from the Welfare and Education Standing Committee, Salt Lake City, Utah, November 1958.

¹²Statement is to be found on the inside cover of the Regulations of the Board of Drugless Therapy; however, it is not an integral part thereof.

¹³R.R.O. 1960, Reg. 121, s. 7 (2).

¹⁴R.R.O. 1960, Reg. 121, s. 4.

The Voluntary Association

The Ontario Naturopathic Association was founded in 1950 and became a Division of the Canadian Naturopathic Association when that body received a Federal Charter in 1955. The membership of the Association has averaged about thirty persons each year, or about 25 to 30 per cent of those who are registered as naturopaths and drugless therapists in Ontario. This membership is voluntary and is open to anyone who is licensed by the Board of Directors of Drugless Therapy. The major activity sponsored by the Association for purposes for promoting naturopathy is an annual convention.

Regulation

Legislation governing the practice of naturopaths in Ontario was first enacted in 1925, when the Drugless Practitioners Act came into effect. This Act, which does not specifically refer to naturopathy, has served until the present time as the legal basis for licensing several healing arts groups, including naturopathy, chiropractic and osteopathy. Until 1953 the Act was administered by a Board of Regents, which was composed of representatives of the various groups regulated by the Act. In 1953 the Board of Regents was dissolved and each group under the Act formed a separate Board of Directors, each of which was authorized to make regulations relating to its particular group of practitioners. The naturopaths, however, were not able to change the "drugless therapy" classification, which was included in the Drugless Practitioners Act, to "naturopathy"; consequently the title of their licensing Board became, and remains today, the Board of Directors of Drugless Therapy.¹⁵ Despite several attempts since its appointment, the Board of Directors of Drugless Therapy has been unable to obtain legislative approval for new regulations which would govern the practice of its registrants.¹⁶

The Board of Directors of Drugless Therapy is composed of five members who are appointed by the Lieutenant Governor in Council for a two-year term, which is renewable. Although the Ontario Naturopathic Association makes recommendations for appointees to the Minister of Health, this procedure is not specifically set out in the Act.¹⁷

The Board consists of a chairman, a vice-chairman, a secretary-treasurer and two members. There is no committee structure within the Board, and all the administrative work is conducted on a voluntary basis by the members of the Board, with the exception of the secretary-treasurer who receives a small remuneration.¹⁸ The Board's income is derived from an initial registration fee of seventy-five

¹⁵This matter was discussed with the Board of Directors of Drugless Therapy, Transcript of the Hearings of the Committee on the Healing Arts, June 14, 1967, pp. 4474-4475.

¹⁶Letter from the Secretary-Treasurer, Board of Directors of Drugless Therapy, June 1967.

¹⁷Board of Directors of Drugless Practitioners, reply to Questionnaire "A", Committee on the Healing Arts.

¹⁸*Ibid.*

dollars, an annual fee of twenty-five dollars and an examination fee of twenty-five dollars for each examination or supplementary examination paper, the total of which must not exceed \$100. Another source of income is interest earned on investments.

The major functions of the Board are set out in the Act and include:

- a) Prescribing the standards for the education and training of naturopaths.
- b) The examination and admission to practice of naturopaths and drugless therapists in Ontario and the consequent registering of the admittees.
- c) Prescribing the discipline and control of registered practitioners and investigating misconduct.¹⁹

The definition of "drugless therapist" which applies at the present time was first stated in regulations made under the Drugless Practitioners Act in 1944:

. . . "drugless therapist" means any person who practises or advertises or holds himself out in any way as practising the treatment by diagnosis, including all diagnostic methods, direction, advice, written or otherwise, of any ailment, disease, defect or disability of the human body by methods taught in colleges of drugless therapy or naturopathy and approved by the Board.²⁰

By 1953, when the Board of Regents was dissolved and the authority for regulating the drugless therapy group was given to the Board of Directors of Drugless Therapy, there were no longer any schools or colleges known as schools of "drugless therapy". But drugless therapy courses were being taught in colleges of naturopathy and in some schools of chiropractic, including the Canadian Memorial Chiropractic College. When the new Board was appointed in 1953, it registered 217 persons who had been registered under the former Board of Regents, plus twenty graduates from the 1949 class of the Canadian Memorial Chiropractic College who wrote and passed drugless therapy examinations under the former Board of Regents, as well as forty-six other graduates of the Chiropractic College who were examined and licensed under the new Board. The last two graduates of the Chiropractic College who qualified for registration by the Board of Directors of Drugless Therapy did so in 1955, and the College has not taught drugless therapy courses since that time.²¹

All of those registrants mentioned above received a certificate of registration as a "Drugless Therapist". Although lacking the authority under the regulations under the Drugless Practitioners Act to do so, the Board has taken it upon itself to issue a separate certificate for registration in naturopathy to those graduates of colleges of naturopathy. All registrants since the last two chiropractors were registered as "Drugless Therapists" in 1955 would come under this second

¹⁹R.S.O. 1960, c. 114, s. 6.

²⁰Originally O. Reg. 214, now R.R.O. 1960, Reg. 121, s. 1 (a). 44, s. 1 (b).

²¹Letter from the Secretary-Treasurer, Board of Directors of Drugless Therapy, to the Committee on the Healing Arts, June 1967.

classification of naturopath. Thus, in spite of the fact that the regulations have provided for graduates of naturopathy schools to be registered by the Board as drugless therapists, they are receiving certificates as naturopaths instead.

As we discussed in the previous section, the education requirements of a registrants under the Board need not be very high. The Board will not grant permission for an applicant to write the registration examinations unless he is at least twenty-one years of age.²² The Board holds registration examinations only once a year and the subjects of examination include:

- a) foundational subjects: anatomy, histology, physiology, bacteriology, chemistry, hygiene and sanitation, diagnosis, symptomatology, pathology, gynecology; and
- b) subjects special to principles of practice, technique and treatment for drugless therapy.²³

The examinations consist of written, oral and clinical examinations in each subject.

As mentioned above, another function of the Board is to set standards for professional conduct and to discipline those practitioners who do not act in accordance with these standards. The Board may suspend or cancel a registrant's licence for "incompetence, misconduct or breach of this Regulation".²⁴ The Board itself admits that it has not sufficiently carried out its disciplinary function and offers as an excuse the limited funds available.²⁵

Laws prohibiting naturopathic practice have been passed in Tennessee, South Carolina and Georgia. Florida has passed a law preventing the licensing of any additional naturopaths.

Our inquiries have led us to the conclusion that the merits of naturopaths are limited. The teachings of naturopaths are not based upon accepted scientific principles, and we have not found any distinctive feature of the practice of naturopathy which has a particular merit on its own. There appears to be no justification for the limited endorsement of naturopathy which is implicit in any statutory recognition. Indeed, that very endorsement, to the extent that it suggests government approval, may itself not be in the best public interest. We have concluded, therefore, that no longer should there be separate legislation regulating the practice of naturopathy or of naturopaths, or that any attempts should be made to recruit new practitioners.

While we do not think it is desirable that any new practitioners of naturopathy should be registered, those presently in practice should be permitted to continue under a special exemption within the revised Medical Act. Our intention is that

²²R.R.O. 1960, Reg. 121, s. 2.

²³*Ibid.*, s. 17, (a), (b).

²⁴*Ibid.*, s. 29 (1).

²⁵*A Comparative Study of Discipline in the Healing Arts in Ontario*, an unpublished study for the Committee on the Healing Arts, 1967.

drugless practitioners not be permitted to practise under more than one classification, and that anyone now practising as both a chiropractor and naturopath divest himself of registration under one of these classifications.

Recommendation:

291 That the present legislation under the Drugless Practitioners Act regulating drugless therapists and naturopaths be repealed and that no legislation to regulate these groups be introduced. Instead, the Committee recommends that an exemption be included under the Medical Act stating that the Act does not apply to those persons who as of the date of enactment are practising as drugless therapists or naturopaths in the province of Ontario and who are registered under the classification of drugless therapists under the Drugless Practitioners Act, provided that they continue to practise within the scope of practice formerly permitted to drugless therapists under the Drugless Practitioners Act including treatment by manipulation, adjustment, manual or electrical therapy, or corrective nutrition. The exempting amendment should also provide that persons wishing to continue to practise under this provision must signify their intent to do so to the Minister of Health, and that they would be prohibited from practising under any other classification of the healing arts.

Natural Hygienists

The approach to illness of natural hygienists is entirely one of prevention. Their beliefs regarding how to maintain a healthy body are largely the same as those of naturopathy. However, natural hygienists sanction almost no positive therapy other than complete rest when a person has been unable to ward off illness. Natural hygienists reject the germ concept of disease, any type of diagnosis, and the application of manipulation, drugs and, in all but cases of absolute emergency, surgery.

The followers of this discipline generally practise under the title of orthobionists. There are only twenty of these practitioners throughout the world, none of whom is in Ontario. There is an organization promoting this doctrine of health in Ontario called the Natural Hygiene Society. Its 100 members, who reside mainly in Toronto, strive to spread their beliefs through means of education and distribution of literature.

In our opinion no specific legislative or regulatory arrangements are required for natural hygienists.

Chapter 23 Sectarian Healers and Hypnotherapy

The groups examined in this chapter are characterized by their reliance primarily upon the use of suggestion in healing. "Suggestion" may be defined as the process of introducing an idea into a mind and bringing about the acceptance of that idea without the use of critical argument or rational persuasion.¹ The sectarian healers do not employ physical or chemical means of healing, but emphasize instead the application of ideas and metaphysical means of therapy. For this reason, the groups discussed here, excluding the hypnotherapists, are sometimes described as "occult" or "sectarian".

The common denominator among these groups, which include Scientologists, Concept-Therapists, Christian Scientists and ontologists, is the use of suggestive therapy. It must be emphasized that almost every kind of healing practice is to some degree unique, and that an element of distortion may arise from considering heterogeneous practices together. The Committee has not approached its studies with any fixed or predetermined idea that certain groups are "scientific" or that certain other groups are "unscientific". The diverse groups considered in this chapter have been brought together somewhat arbitrarily, partly because they appear to share certain similar approaches to healing, and partly for convenience in research and analysis.

We also wish to emphasize that no one can draw a hard and fast line, even for analytical purposes, between groups which employ suggestive therapy and groups which do not. There is an element of suggestion inherent in most healing arts, indeed, in most human relationships. The use of placebos, a warm and friendly bedside manner, or expressions of confidence in a patient are all examples of the utilization of suggestive therapy by physicians. When the application of techniques of suggestive therapy is combined with a "scientific" method of diagnosis and analysis, we remain within the normal realm of "medical practice". Sectarian groups, however, must be considered in a different category. They base their healing practices on a particular system of belief and a particular interpretation of reality, and employ suggestion as the principal technique of therapy. The Committee does not attach any connotation of discreditable practice to the use

¹John A. Lee, *Sectarian Healing and Hypnotherapy in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, Ch. 1.

of the phrase "healing by suggestion". We are mindful of the fact that the basis of scientific progress is a constant re-examination of accepted theories, and that practices which may be unorthodox or unscientific in one century may come to be regarded as orthodox and scientific in the next.

The inclusion of hypnotherapy in a chapter with sectarian healers is not meant to imply that hypnosis is occult. Hypnosis itself is a technique, not a treatment, and there are many legitimate therapeutic and clinical applications of hypnosis. The common characteristic of the use of suggestive therapy, however, has led to the inclusion of hypnotherapy here.

The Committee was not directed by its terms of reference explicitly to investigate matters of religion, or religious freedom. Nevertheless, where certain churches make overt and explicit claims to heal, we have found it necessary to examine the nature of their claims, and the nature of their healing practices, with no intention of infringing upon the traditional religious liberties within society. The churches which have come within the purview of our inquiry promulgate explicit doctrines as to the nature of disease, and remedies for human suffering. The Committee recognizes that the causes of disease and human illness are not always clear even to the most exacting scientist, and that mental, emotional and spiritual factors can affect physical disorders.

We approached this area of sectarian healing with the same circumspection that we applied to other disciplines. Just as we did not devote particular study to particular branches of medicine, such as cardiology or paediatrics, neither did we examine in detail every possible branch of healing by suggestion. A study of sectarian healers was carried out for us by John A. Lee, now of the Department of Sociology, University of Toronto; this study, *Sectarian Healing and Hypnotherapy in Ontario*, is one of the volumes being published with this Report. Lee's work included an examination of a large representative sample of various heterogeneous groups, which purport to heal mainly through the use of suggestion. The following groups were studied: Church of Christ, Scientist; Church of Scientology; Concept-Therapists; electropsychometrists; spiritual healers; faith healers — Oral Roberts Mission; Unity Church of Truth; ontological centres. Much of the material in this chapter is derived from Lee's study.

The sectarian healing groups selected for discussion met certain criteria. All the groups possess a distinct system of beliefs which would lead to the adoption of a certain form of treatment for human illness; all the groups claim, either expressly or implicitly, to relieve or cure conditions which normally are within the scope of the healing arts; all the groups make available to Ontario residents instruction in, or practice of, their system of belief, and in all the groups the instruction or practice of their system of belief is an important part of their activities. Although there are only two practitioners of electropsychometry in Canada, one of whom practises in Ontario, we found the theory of electropsychometry and its influence upon other groups sufficiently relevant to include some reference to its practices in this chapter.

The Committee's main interest in these groups has been to discover the extent of their healing claims, and the particular practices used. We have had no desire to condemn practices which are merely different and might seem mysterious to many people. Since the groups considered here do not fit easily into the categories under which the more orthodox healing professions have been discussed, a different set of categories has been used to examine them. In addition to publishing Lee's study, we have found it desirable to include here a summary of the general characteristics of sectarian healing. Because of the particular issues raised by their practices, we have examined in greater detail and devoted separate sections to the Church of Christ, Scientist, and the Church of Scientology. Hypnotherapists and the use of hypnosis also are dealt with separately. Because of the difficulty of obtaining exact figures, we have been able to include only rough estimates of the number of people who resort to sectarian healers for help or who belong to sectarian groups.

Characteristics of Sectarian Healing

Claims

The Committee's attention focused on two aspects of the healing claims made: first, the extent of the claims — that is, the type of disease or suffering for which a cure or relief was offered; and second, the official policy of the groups towards medical practitioners and the behaviour expected of adherents of the groups regarding their relations with physicians.

Only one of the groups studied claims to replace medicine almost completely. Christian Science doctrine regards material existence, including pain and illness, as illusion. The cure of sickness is realization that it is an illusion, and Christian Science practitioners will not treat members who are receiving medical care. Certain concessions are permitted in practice, however, and were sanctioned by the founder, Mary Baker Eddy, whose works are regarded as being divinely inspired. Dental treatment, childbirth and major surgery are recognized as legitimate areas in which to admit the temporary weakness of the mind in fighting illusion.

A contrast to this attitude is the policy of a number of the smaller groups which make no claims to rival medicine. The brief of the Spiritual Healers of Ontario to the Committee on the Healing Arts stated that "Spiritual Healing can be used to supplement the treatment by the medical profession", and concluded "that it is essential that the healer recommend that the patient continue to report to his doctor faithfully and to continue any form of treatment prescribed".² Both ontologists and practitioners of Unity seek merely to provide the spiritual conditions that are felt to be an essential foundation for mental and physical recovery; ontologists claim no specific cures, while practitioners of Unity place no limit

²The Spiritual Healers of Ontario, Brief to the Committee on the Healing Arts, 1966, p. 3.

on the healing power of prayer to cure disease. The Oral Roberts Healing Mission also claims cures of all manner of disease, but recognizes the parallel role of medicine.

Three groups concentrate their claims on the relief of psychosomatic illnesses, which are estimated by some of them to be between 70 and 80 per cent of human ills.³ Both Concept-Therapists and Scientologists base their theories upon increasing the self-awareness of the individual. Concept-Therapists leave the relief of non-psychosomatic disease to medical practice, but claim that the relief of the 80 per cent of man's illnesses which they believe to be psychosomatic can be achieved by application of the mental powers of human consciousness. Scientologists sometimes disclaim any interest in healing physical or mental disorders; however, they also claim that 70 per cent of human illness is psychosomatic and can be cured by Scientology. Volney Mathison, the inventor of the electropsychometer, claimed that the combined use of the E-meter and self-hypnosis tapes was an effective technique for the diagnosis and cure of psychosomatic diseases and for psychological self-improvement. He did not, however, make any claims for the use of electropsychometry to cure physical illness.

Organizational Structure

A significant feature of most of the groups is the strict control exerted by the organizational centres over their practitioners and members. None of the groups has been in existence for more than a century, and all, except the spiritual healers, are still ruled by the doctrines of, or directly controlled by, the founders. There is, however, no organization linking the practitioners of electropsychometry; after the death of the founder all central direction ceased, and practitioners are not subject to any type of control by other practitioners. With the exceptions again of the spiritual healers and the electropsychometrists, the organizations of the various sectarian healers tend to be hierarchical, with much downward and little upward communication.

The autocratic control of the Church of Christ, Scientist, by Mary Baker Eddy has been transferred to a five-man self-perpetuating Board of Directors which manages the affairs of the Mother Church in Boston. Christian Scientists can belong to the Mother Church, a branch church, or both, although at least four members of each branch must belong to the Mother Church. The members have no voice in the running of the Mother Church by the Board; no reports are issued and disciplinary actions by the Board cannot be appealed. This disciplinary action is exercised by the authority possessed by the Board to expel members, and to control the accreditation and listing of practitioners and teachers in the *Christian Science Journal*. Since *Journal* listing is usually the standard of accreditation employed by insurance schemes which recognize Christian Science treatments, the power to remove a practitioner's name from the *Journal* is a potent disciplinary weapon.

³John A. Lee, *op. cit.*, pp. 59, 92, 96.

Unity and ontology have a looser organization in that there are no regular members of either the local branches or the central body. Anyone is allowed to visit their branches although there are, of course, regular participants. Descendents of the Fillmores, founders of the Church of Unity, control the assets and publications of the international church and a small board of officials controls each local church. The Second Bishop of the Emissaries (the first was the founder) is the head of the ontologists, and below him are twelve reverends, who are regional leaders. This group of thirteen controls the central assets and publications of the organization. The local centres are headed by servers, who function as "ministers".

Three groups, Scientologists, Concept-Therapists and the Oral Roberts Healing Mission, are directly controlled by the founders. L. Ron Hubbard is the founder and principal influence within the Scientology organization. There are two parallel branches: the Church of Scientology of California, controlling most of the training activities; and the Hubbard Communications Office, controlling Scientology publications and discipline. The hierarchy extends down from the international centre in England through national centres, city offices and franchises in smaller towns. Members have no voice in the administration, financial affairs or policy-making of the central body.

The Concept-Therapy Institute at Boerne, Texas, is run by the founder, Thurman Fleet, who personally controls the assets and publications. Members of the local clubs have no voice in the running of the Institute. The Oral Roberts Healing Mission runs highly organized crusades from a central organization under the personal direction of Oral Roberts. There are no local clubs or members, but regional offices carry out the detailed administration of the healing campaigns with the cooperation of local ministers.

Spiritual healers rely a great deal on personality and individual followings, and there is no one central organization linking all of them. Instead a number of groups and federations have grown up, often with cross-links among them. The United Spiritualist Church of Ontario is a group of non-Christian churches, while the Toronto Spiritualist Temple with its branch churches is one of the groups of Christian spiritualists. Also in operation in Ontario is the Canadian section of the National Federation of Spiritualist Healers, a British organization which is trying to unite and establish common standards for all spiritualist healers in Britain.

Healing Practices

The healing practices employed by the sectarian healers actually vary a great deal, in spite of many apparent similarities in doctrine and organizational structure. All the groups, of course, employ the power of suggestion in their healing techniques, yet the forms in which suggestion is used range from the establishment of a warm and meditative atmosphere for prayer, to the impassioned oratory of a healing crusade, to intensive personal questioning over a period of possibly several hours. Certainly some of the practices used may be regarded as unusual or unorthodox

by most of society; however, in this section the techniques are noted without comment, critical or otherwise. A much fuller account of the healing practices of each group can be found in Lee's study.

Every Christian Scientist is a "practitioner"; some members become accredited practitioners by the central organization and are resorted to by ordinary members in time of need. These accredited practitioners are listed in the *Christian Science Journal*. The central act of healing is knowing that pain and disease are an illusion. If the member finds his own understanding insufficient, he consults an accredited practitioner, in person or by telephone or mail. The practitioner uses a two-fold healing technique: arguing down the illusory symptoms to the patient, and meditating on the client's symptoms and their unreality. No diagnosis is made, but clients must make a choice between medical and Christian Science treatments. If the Christian Science treatment is a failure, the member is at liberty to consult a physician.

Concept-Therapists are also expected to be their own practitioners. Members are trained to heal themselves and those around them by the reduction of destructive suggestion and the implanting of healthful, constructive concepts. Concept-Therapy training emphasizes the many sources of suggestion in daily life, and teaches the techniques of self-hypnosis to strengthen the retention of healthful suggestion. There is no opposition to the use of drugs or medical care, although it is believed that the ailments which can be treated effectively by medical science are only a small proportion of all illnesses. The founder of Concept-Therapy believed that Concept-Therapy training would be most useful to existing practitioners in the healing arts; however, only chiropractors (and a small minority of them) seem to have responded favourably to the healing doctrines of Concept-Therapy.

Practitioners of electropsychometry exemplify the most direct use of suggestion in their healing activities. Each day, prior to sleep, the client listens to alternate halves of a two-hour tape. The tape begins with a relaxation procedure, then goes on to an analysis of specific problems and assurance that these problems are over and that the client's energy should be turned to healthful activity. The practitioner prepares the tape for each client after an analysis session using an electropsychometer, a form of lie detector which is sensitive to physical manifestations of emotional reactions.

E-meters are used also by Scientologists, whose main therapeutic technique is "auditing". In this process a trained Scientologist asks a question or issues a command to a client or "preclear" until the auditor is satisfied, frequently by means of a reading taken on an E-meter, that the preclear has mastered the process or revealed a mental block or "engram". A primary level of training is Dianetic auditing. Dianetics was a theory of mental health popularized by Hubbard two years before he announced the discovery of Scientology. In Dianetics, the auditor tries to "discharge" painful experiences or engrams stored in the subconscious of the preclear. In Scientology, preclears are being trained to achieve

“clear”, the state of complete self-determination of all individual actions with a view to attaining the level of an operating Thetan. The final stages are mastered by the preclear himself, using an E-meter. There are two routes to clear: training and processing. The former route, which takes longer, is preferred by the organization, since the preclear learns how to audit others and thus becomes a potential staff member. The contract which the preclear signs stipulates that no psychiatric treatment is being taken or will be taken during auditing, and that the organization is the judge of the amount of time needed to master each stage. Although Scientologists disavow any interest in physical healing, they may use a process known as “assist therapy” for physical injuries. The practitioner places his hand just beyond the point of injury, while the patient focuses attention on the practitioner’s hand to direct healing energy to the painful area.

Ontologists do not regard their treatments, or “attunements”, as a specifically healing procedure, but rather as a means of restoring balance and harmony to the life-forces; thus there is no attempt to diagnose specific ills. The patient lies on a couch and the practitioner places his hands near the patient’s ears. Complete silence is maintained and the attunement is continued until the patient is clearly relaxed.

Healing services at Unity churches also aim at providing a quiet, relaxing atmosphere with music and the repetition of healing formulas by the minister. Absent healing is provided through the Silent Unity Prayer Service at the church headquarters.

Physical contact between the practitioner and patient is used by both spiritual healers and Oral Roberts and his healing team. Spiritual healers are the most individualistic practitioners among the sectarian healers; however, there are certain common characteristics in most treatments. The client sits in front of the healer, who then grasps his head or shoulders. Some healers maintain this position while the warmth and pressure of the grip relaxes the patient; other healers move their hands over the client’s body to draw out evil energies. During an Oral Roberts healing crusade, the sufferer is grasped by the head or shoulders while Roberts invokes the power of Jesus to heal.

St. Mathias Church

During the course of our deliberations, an unfortunate event occurred in Toronto involving members of a group associated with the St. Mathias Anglican Church. An inquest into the death of a member of the group, Miss Katherine Globe, suggested the harm which can result to adherents of sectarian healing groups. In mentioning this case, we do not imply that the events at St. Mathias Church are characteristic of the policy or practices of the Anglican Church of Canada on questions of healing. A detailed description of the activities of this group and the events which led to the death of Miss Globe, the legal ward of the rector of St. Mathias,

are given in Lee's study.⁴ A further appraisal, of the St. Mathias ministry in particular, and of the Church's responsibility in the care of the sick in general, was made by the Bishop of Toronto's Commission on the Church's Ministry of Healing⁵ subsequent to the inquest.

The St. Mathias group began as members gathered for prayer and spiritual healing under the leadership of the rector of the Church, his assistant who was also an Anglican priest, and a lay member of the congregation. The group became more and more concerned with the presence of evil in the lives of distressed people and gradually evolved into a mystic cult. About sixteen persons lived in the group's community house. Any emotionally troubled person who entered the group would be warmly received and given strong emotional support by the leadership. In exchange for this support and other assistance, he was expected to share all his thoughts and feelings with other members of the group. "This meant the sacrifice of independence of thought and autonomy of action. It meant relinquishment of all significant emotional contact with any family members who may threaten the relationship with the new 'family in God' (the group)."⁶ The group engaged in such practices as exorcism of the devil, "speaking in tongues", shaking, and using the hearing of voices as a form of guidance. It should be noted, however, that by and large the need for medical, surgical or psychiatric treatment, when appropriate, was accepted. This is evident in the case of Miss Globe who, for several weeks prior to her death in June 1967, had been seen on seven occasions by physicians on an outpatient basis at a Toronto hospital. In the judgment of the coroner's jury, the rector was guilty of neglect in not summoning or seeking medical aid on the two days immediately prior to the girl's death. The Bishop of Toronto's Commission noted, however, that neither the girl nor her guardians had been warned by any physician of the serious nature of her illness, and doubted if any one physician had been aware of its urgency. This was also recognized by the jury, which expressed concern at the lack of communication among physicians at the hospital treating the girl. There was expert evidence presented at the inquest, however, that had Miss Globe received medical attention within the twenty-four hours preceding her death, the death could have been averted.

As we have stated at the beginning of this chapter, we have no desire to condemn practices which are merely different and might seem mysterious to many people. But we feel that closed communities, such as the "demon cult" at St. Mathias, which are organized by sincere but misguided or untaught persons, and which bring powerful psychological and religious sanctions to bear on the emotional lives of their members, can do serious harm to the emotionally troubled who turn to such groups at times of difficulty and are consequently cut off from proper professional help.

⁴*Ibid.*, pp. 123-126.

⁵The Report of the Bishop of Toronto's Commission on the Church's Ministry of Healing, May 1968.

⁶*Ibid.*

Reward for Healing

Like therapeutic techniques, the demand or expectation of reward for healing varies greatly among the various groups. An effective dividing line can be drawn between those groups which charge fixed fees for service, and those which rely on donations. Scientologists, Concept-Therapists, Christian Scientists, and electropsychometrists comprise the former group; ontologists, spiritualists, the Church of Unity, and the Oral Roberts Healing Mission comprise the latter.

The manner in which Scientologists charge for auditing is unique among the sectarian healing groups. Preclears sign a contract to pay in advance for most services, and are expected to pay for hours of auditing beyond those stipulated in the contract if the organization feels it to be necessary. The preliminary courses are priced low to attract people; the more advanced courses become increasingly expensive. A personal efficiency course costs five dollars for five evenings; a five-evening communications course costs fifteen dollars. By the time the preclear reaches the stage of individual auditing, the price is thirty dollars an hour, and the preclear is expected to buy his own E-meter from the organization at a cost of \$140. The total cost of becoming "clear" can run into thousands of dollars, although often preclears pay part of the charge by working at the Scientology centre. In Toronto in 1967 the number of clients per week in all levels ranged between ten and twenty-five.

Christian Science practitioners charge fixed rates for treatment. Rates tend to be lower than those charged by physicians, and repeated treatments are given at a reduced rate. Average charges would be five dollars for a personal visit, and four dollars for treatment by mail or telephone. Toronto practitioners each receive ten to fifteen requests for treatment each week.

The one practitioner in Ontario using electropsychometry charges twenty-five dollars for the E-meter analysis and sixty dollars for the tape recording produced. His estimated clientele is about three per week.⁷

The weekend courses in Concept-Therapy, taught by teams of two instructors sent out to various cities from the Concept-Therapy Institute, each cost \$100 per student. There are no specialized practitioners of Concept-Therapy as such, but a small number of chiropractors have been trained in Concept-Therapy theories; Lee's study found that fourteen Ontario chiropractors had received Concept-Therapy training.⁸

The four groups which rely on donations receive more modest rewards, although the Oral Roberts healing crusades attract such large numbers that the total income is large. Ontologists receive donations of two to three dollars per attunement, while spiritual healers earn fifty cents to two dollars for healings at meetings and by letter. The donations made to the Unity Church are similar. About 100 attunements a week are given at the three Toronto ontology centres.

⁷John A. Lee, *op. cit.*, p. 91.

⁸*Ibid.*, p. 100.

Training the Practitioner

Since the practitioners of the sectarian healing groups claim to help or heal people who come to them, it is the concern of the Committee to examine the ways in which these practitioners are trained. Given the extensive use of suggestive therapy in sectarian healing, a matter of special interest to us was the instruction in psychology and psychotherapy, or lack of it, available to potential practitioners.

We found that as a general rule training is not based upon any minimum educational standard, nor does it involve any accredited and recognized academic institution. The methods and content of training vary widely.

The only group which does require an academic qualification, high school graduation, is the ontologists. Students can train to be either servers or ontologists, the latter course requiring four additional weeks of training after the first twenty-one weeks. Attunements usually are given by trained ontologists, although they may be performed by servers. Recognition as a server or ontologist is accorded by the Bishop on the basis of academic accomplishment and personal conduct during the course, with much emphasis being laid upon unselfish communal living and development of a warm personality. The course is held at the group's headquarters in Colorado, and instruction is given in anatomy, metaphysics, public speaking, nutrition and human relations.

The most elaborate training is that given by the Scientologists. To become "clear" a Scientologist requires training that involves over 2,000 hours. After a preliminary sixteen-week course, five evenings a week, the preclear begins to be audited through levels zero to six, the last two being taken at the international headquarters in England. The training emphasizes Scientology theory, and obedience and involvement by the student are required, even to the extent of severing family relationships deemed to be harmful to the student's progress. No training is given in psychology. The cost of the training varies with the student, since at the beginning of his training he agrees to take as many hours of auditing as the organization feels to be necessary for him to master each level.

Concept-Therapists have no practitioners as such, but the theory of Concept-Therapy is taught at seven weekend courses. Graduates of the first course, which is a basic introductory course, are qualified to join local Beamer clubs, of which there are about 250 in North America. Five further courses in Conceptology elaborate the principles outlined in the first course, and the seventh course, in suggestive therapy, is designed for the special needs of chiropractors. During the courses, students are taught techniques of hypnosis, basic principles of psychoanalysis, and the metaphysical doctrine evolved by the founder.

Unity also does not have specialized practitioners of healing, although local churches have ministers who are selected, trained and ordained by the central organization. Classes are held at the local churches for anyone who wishes to attend, to give instruction in Unity doctrine and approach to healing.

Christian Science classes are restricted, in order to control the number of practitioners. Every Christian Scientist is expected to practise healing on himself and others, but certain among them practise for financial reward. Although there is nothing to prevent any member of the church from receiving a fee for helping another member, only accredited practitioners are listed in the *Journal* and thus recognized for insurance claims and income tax deductions. Accredited practitioners must be members of the Mother Church, have supplied testimonials of healing from three members, attended a Primary class, and been approved by the Board of Directors. Primary classes are limited to thirty students, and are conducted by teachers over twelve evenings. Once every three years, thirty students are chosen by the Board of Directors for the Normal class, a short course which qualifies the graduates as teachers. Teachers enjoy higher status than do mere practitioners and are permitted to hold one Primary class a year. Since Christian Science doctrine regards disease, and thus medical remedies for disease, as illusory, training is given from the works of Mrs. Eddy and does not include any instruction in anatomy or psychology.

Training in electropsychometry ceased at the death of Volney Mathison, the founder. Before his death, he taught the use of the E-meter and the preparation of tapes by a correspondence course of two volumes, which contain many examples of treatment performed by him and metaphysical explanations of the treatments.

Spiritual healers are trained on an individual basis by the local church. Members who seem to have hidden healing power are allowed to heal under the supervision of a recognized healer. The National Federation of Spiritual Healers, Canadian Section, has established a correspondence course dealing with anatomy and spiritual healing, similar to that run by the National Federation of Spiritual Healers in Britain. The Federation hopes to standardize and upgrade Canadian practice by enrolling all practitioners in the course, and accrediting those who successfully complete it.

Oral Roberts and his "team" have no specific training in healing and do not train others. The Oral Roberts University School of Evangelism in Tulsa, Texas, includes training in the doctrine and practice of Christian healing.

Regulation of Practitioners

This section deals with legislative regulation, both in Ontario and in other jurisdictions. The sections on Scientology and Christian Science below examine in greater detail the legislative provisions affecting these two groups.

Legislative Regulation in Ontario

The statutes of Ontario do not define what constitutes the practice of medicine;⁹ but before the prohibition against anyone not registered under the Medical Act from practising can be enforced by prosecution, it must be shown that an act was

⁹See Chapter 25, for further discussion.

done for "hire, gain, or hope of reward".¹⁰ Consequently, members of sectarian groups would not be prevented from practising any form of healing as long as they did it without hope of reward and without infringing the criminal law.

Legislative Regulation in Other Jurisdictions

The limiting criteria of the definition of the practice of medicine used elsewhere in North America, where such practice is defined, include treatment of physical conditions, treatment of physical and mental conditions, cure of the diseases, and preservation of the health of man. In general, the definitions in most North American medical Acts attempt to place definable limits on the practice of medicine, and to restrict such practice to members of the medical profession. A contrast to this approach is the "open practice" approach of Britain and some Australian states, which involves the principle that citizens are free to patronize any practitioner or practise any form of healing, provided that practitioners do not contravene the criminal law or claim to be registered when they are not. There are certain limitations placed on open practice, however. For example, unregistered practitioners would not be employed by any form of public health services, and in some jurisdictions would not be able, through legal action, to recover fees charged (although there is no restriction upon the charging of fees by unregistered practitioners). In the United Kingdom, only registered practitioners are permitted to treat certain specific conditions such as venereal disease, or to sign certain official certificates such as death certificates.

Recognition and Exemptions

Throughout the world, the extent of formal public recognition of sectarian healing practices is limited. In general, only Christian Science practitioners are given status similar to medical practitioners for income tax purposes, and by a few private insurance companies. Several Workmen's Compensation Acts outside of Canada provide for the payment of benefits to persons receiving Christian Science treatment, but Lee reports that no Canadian boards follow this practice.¹¹

In England, over 2,000 hospitals under the National Health Service have agreed, since 1960, to allow spiritual healers to see a patient in hospital if the patient so desires and if the attending physician does not object.

Four Canadian provinces and the majority of American states exempt healing by prayer or the practice of religious tenets from the provisions of the Medical Act and/or the Basic Science Law. The British Columbia Medical Act, 1960, states that "Nothing in this Act contained applies to or affects those who practise the religious tenets of their church without pretending a knowledge of medicine or surgery" (section 73).

¹⁰R.S.O. 1960, c. 234, s. 51.

¹¹John A. Lee, *op. cit.*, Appendix IV, p. 172.

In Ontario, the Medical Act makes no such exemption; however, the Drugless Practitioners Act¹² and the Chiropody Act¹³ both exempt from their provisions "persons treating human ailments by prayer or spiritual means as an enjoyment or exercise of religious freedom".

In general, there are no exemptions permitted to any group or individual from the provisions of legislation concerning sanitation and contagious diseases. A few American states do permit those suffering from communicable diseases requiring compulsory hospitalization and treatment to remain isolated in their own homes and accept treatment by prayer or spiritual means. Exemptions from immunization programs for contagious diseases, however, as opposed to exemptions for the treatment of contagious diseases, are not unknown in Canada. For example, the Manitoba Public Health Act states that:

The following persons are exempt from vaccination or inoculation:

- (a) a person who makes a statement in writing that he believes vaccination or inoculation for the prevention of disease is prejudicial to health or that it is opposed to his religious beliefs, and furnishes the statement to the medical officer of health;
- (b) the child or ward of any such person.¹⁴

Ontario Department of Education regulations permit the exemption of children from health education classes when the parents object to such classes on religious grounds.

The Church of Christ, Scientist

Because of its size, and the special recognition accorded to it in many jurisdictions, the Church of Christ, Scientist, enjoys a unique position among the sectarian groups studied by the Committee. This section deals with certain aspects of Christian Science practice and organization, including legislative recognition, in greater detail than was either necessary or possible for the other groups.

In the brief presented to the Committee by the Christian Science Committee on Publication for Ontario it was stated that:

Since Christian Science is the practice of religion, and since Christian Science practitioners are engaged in a religious ministry, not the practice of any form of medicine or material system of healing, it is clear that they are not to be considered within the province of the Medical Practices Act.¹⁵

The Committee on the Healing Arts, however, felt that the practices of the Church of Christ, Scientist, came within the purview of the Committee's investigations. The "healing arts" cannot be defined in a narrow or restrictive sense to

¹²R.S.O. 1960, c. 140, s. 10(d).

¹³R.S.O. 1960, c. 54, s. 7(d).

¹⁴The Public Health Act, Manitoba, 1965, c. 62, s. 37.

¹⁵The Christian Science Committee on Publication, Brief to The Committee on the Healing Arts, 1966, p. 18.

include only material systems of healing. Moreover, the Committee noted that the Christian Science brief also claimed that:

Christian Science treatment has proved effective in healing all types of diseases and ailments, organic as well as functional . . .¹⁶

and that specific conditions such as burns, tuberculosis and asthma had responded to Christian Science treatment. Accordingly, our investigation of the healing arts could not overlook the practices of Christian Scientists.

Membership

The problem of obtaining membership figures which the Committee encountered with the other sectarian groups did not arise in the case of the Church of Christ, Scientist. Its position as a recognized religion means that membership figures are available for census years, and the *Christian Science Journal* lists practitioners accredited by the Board of Directors. The figures in Tables 23.1, 23.2 and 23.3, together with the fact that the Christian Science practitioners in Toronto are all over fifty years old, indicate the decline in the following of the sect in Toronto.

TABLE 23.1
Number of Christian Scientists in Canada, Relative to Population, 1901-1961

Year	Population of Canada	Adherents of Christian Science
1901	5,371,000	2,644
1911	7,206,000	5,099
1921	8,787,000	13,856
1931	10,376,000	18,856
1941	11,506,000	20,261
1951	14,009,000	20,795
1961	18,238,000	19,466

SOURCE: John A. Lee, *Sectarian Healing and Hypnotherapy in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 37.

TABLE 23.2
Numbers of Christian Scientists by Region and Sex, 1961

	Canada	Ontario	City of Toronto
Male	8,526	3,400	437
Female	11,210	4,663	807
Total	19,736	8,063	1,244

SOURCE: John A. Lee, *Sectarian Healing and Hypnotherapy in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 42.

¹⁶*Ibid.*, p. 9.

TABLE 23.3

Recognized Christian Science Practitioners in Metro Toronto Area, 1941-1967

Year	Number of practitioners
1941	64
1945	58
1950	53
1955	50
1960	42
1967	30

SOURCE: John A. Lee, *Sectarian Healing and Hypnotherapy in Ontario*, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 38.

In Canada, three-quarters of the societies (which have under sixteen members) and of the branch churches of Christian Science are located in two provinces, Ontario and British Columbia. Ontario has twenty-seven churches, six in Toronto, and fourteen societies.

Activities

In addition to the Christian Science practitioners whose training and practices have already been outlined, there are Christian Science nurses and sanatoria. The brief of the Christian Scientists to the Committee explains that although the physical needs of the patient are cared for by the nurse, no form of physical therapy is attempted by a Christian Science nurse. "A medical nurse would be as unqualified to take care of a patient relying on Christian Science for healing as would be a Christian Science nurse to undertake to care for a patient under medical care."¹⁷

Training for Christian Science nurses is given in three-year courses at the two sanatoria: one in Chestnut Hill, Massachusetts and the other in San Francisco, California, both run by the Mother Church. The Board of Directors of the Mother Church accredits nurses, as it does practitioners, and lists them in the *Christian Science Journal*. Only Christian Scientists receiving treatment from Christian Science practitioners are eligible for nursing care from accredited nurses, who work in sanatoria, nursing homes and home care programs. In Toronto, a Christian Science Visiting Nurse Service has been operating since 1949.

The sanatoria operated by the Mother Church in Massachusetts and California provide non-medical nursing care for members of the Church. Other accredited sanatoria are operated privately, in the United States, Britain and Canada. The only one in Canada at present is in Victoria, British Columbia, but one is planned for Ontario. The sanatorium will not be required to have a licence, because the Ontario Department of Health has made an informal ruling that the proposed institution, being non-medical, is not a nursing home within the meaning of the Nursing Home Act.¹⁸

¹⁷*Ibid.*, p. 13.

¹⁸R.S.O. 1960, c. 99.

Recognition

The Church of Christ, Scientist, has double recognition in most North American jurisdictions as both a religious and a healing organization. For census purposes it is regarded as a religion, yet receipts from Christian Science practitioners, nurses and sanatoria are deductible as equivalent to medical expenses for both Canadian and American income taxes.

Christian Science is more often referred to specifically in American than in Canadian legislation. For example, the United States Social Security Medicare Act (Public Law 89-97), enacted in 1965, recognizes Christian Science sanatoria as the equivalent of both medical hospitals and extended care facilities. A number of Workmen's Compensation Boards in American states permit payment of compensation benefits to Christian Science practitioners. The Ontario Board, however, has refused to allow a similar practice in this province, despite requests for recognition from the Church of Christ, Scientist. Some insurance companies also pay for Christian Science treatments and care through both group health schemes, and casualty and accident policies. According to a brief submitted to the Royal Commission on the Workmen's Compensation Act in 1966 by the Christian Science Committee on Publication for Ontario, the insurance companies with such provisions include Metropolitan Life, Travelers and the Aetna Life Insurance Company, which runs the Indemnity Benefit Plan for Active Federal Employees.¹⁹ Christian Science nurses usually are exempted from the provisions of nursing acts, either because their care is limited to "spiritual services" or because they do not claim registration. The Nurses Act of Ontario, 1961-1962, does not contain a specific exemption provision; however, its provisions apply only to nurses registered under the Act. There has never been any attempt to restrict the practice of Christian Science nurses in Ontario.

Christian Science sanatoria are exempt from medical supervision but have to comply with safety and sanitary requirements, and are inspected by public health officials.

Scientology

With no other group in the healing arts did the Committee encounter the uncooperative attitude evinced by the Church of Scientology. A fuller discussion of the doctrines and practices of the Church of Scientology can be found in Lee's report; we present here a brief outline of the Committee's dealings with the Scientologists, and a selection of the evidence which the Committee obtained concerning the healing practices of the group.

Although the Scientologists refer to their organization as a "church", and although we will use that designation to describe it, this Committee views with skepticism the claims of Scientology to be a "religion". Such claims seem to us

¹⁹The Christian Science Committee on Publication for Ontario, Brief to the Royal Commission on the Workmen's Compensation Act, August 10, 1966, p. 6.

somewhat disingenuous, concealing more than they reveal concerning the real nature and beliefs of the organization. Our reasons for this skepticism will become evident in the material which follows.

During the course of Lee's investigations of various sectarian healers, he informed the Committee that he had reason to believe that the theories and practices of the Church of Scientology brought them into the field of the healing arts, particularly the area of mental health. Lee reported some difficulty in obtaining necessary information from the Scientologists. At the same time, the Church of Scientology complained of the nature of Lee's investigation.

After carefully assuring itself that Lee's inquiry had been conducted in a moral, scholarly and straightforward manner, this Committee informed the Church of Scientology that we required further information similar to that which we had already obtained from more than forty other groups whose activities were relevant to the work of the Committee, and specifically requested the cooperation of the Scientologists. On August 17, 1967, the Committee's standard form of inquiry, Questionnaire "B", was sent to this group. They declined to fill out the questionnaire. Instead the secretary of the Board of Directors of the Church of Scientology, California, Mrs. Monica Quirino, wrote to the Committee on August 30, 1967, that Scientology bore no relation to the healing arts and that their religious technology should not be "subject to your Committee's evaluation". Mrs. Quirino found our inquiry "so shocking" that she advised us of the Church's intention of reporting us to "the Prime Minister of Canada and the Member of Parliament for Toronto". Further correspondence passed between the Executive Secretary of the Committee and officers of the Church of Scientology in Toronto, but no further information was obtained, and we were told that local officers of the Church were not permitted to grant interviews.

Having failed to secure the voluntary cooperation of the Church of Scientology, and having exhausted all other forms of procedure, the Committee caused a subpoena to be served upon officers of the Church of Scientology in Toronto on November 3, 1967, requiring them to attend at a hearing and to produce certain literature and documents pertaining to their beliefs and practices. Two requests for delay by the Scientologists were granted by the Committee: the first on November 20, 1967, to enable the Scientologists to secure counsel; and the second, on February 5, 1968, to permit counsel for the Scientologists to prepare his representations.

Eventually representatives of the Church of Scientology, with counsel, and with a representative of the Church from New York, did appear before the Committee at a hearing on March 4, 1968. Although their representatives did answer some questions put to them, and did provide copies of certain documents and literature as requested, they continued to protest that they were not within the healing

arts and they declined once again to provide answers to Questionnaire "B" as requested. The Committee then prepared another questionnaire, Questionnaire "F", specially adapted to the peculiarities of the Church of Scientology, in an effort to elicit information.

The next response of the Scientologists was to loose a volley of highly offensive press releases during the month of November 1968, attacking individual members of the Committee, accusing at least one member of "crimes", impugning the motives of the Committee, accusing the Committee of conducting an "Inquisition" and charging that the Committee's investigation was "outrageous", "dangerous", and a "fast route to fascism".

Such tactics, as we later learned, are regarded in many jurisdictions as characteristic of the Church of Scientology. It is their normal practice to attack any individual or organization which attempts to investigate the Church of Scientology. The founder of the Church, L. Ron Hubbard, in an Executive Letter of September 5, 1966,²⁰ instructed his followers how to deal with those who attempt to inquire into the practices of the Church:

To: Scientologists

From: Ron

Subject: How to do a NOISY Investigation

Further to H.C.O. Executive Letter of 3rd August, 1966, Cathy Gogerly, H.C.O. Area Sec., Adelaide, Australia, has given details of how to go about dealing with attackers of Scientology.

Here's what you do.

Soon as one of these threats starts you get a Scientologist or Scientologists to investigate noisily.

You find out where he or she works or worked, *doctor*, dentist, friends, neighbours, *anyone*, and phone em up and say, "I am investigating Mr./Mrs. . . . for criminal activities and he/she has been trying to prevent Man's freedom and is restricting my religious freedom and that of my friends and children, etc. . . .".

You say now and then, "I have already got some astounding facts", etc. etc., (Use a generality) . . . It doesn't matter if you don't get much info. Just be NOISY—it's very odd at first, but makes fantastic sense and WORKS. (Honestly, you feel a real dill, it's so reverse to all detective work).

You will find that Scientologists will come rushing forward with 90% of your facts anyway. (They are never from auditing sessions). Scientologists are really terribly ethical.

Best and love,

Cathy.

L. Ron Hubbard

We are forced to conclude that such statements represent the typical attitude of this group. The press releases on the subject of this Committee issued by the

²⁰Quoted on pp. 7-8 of a Written Answer in the House of Commons, Great Britain, No. 1459/1967/68; 26 July, 1968, provided by the Honourable Mr. Robinson, Minister of Health.

Church of Scientology are entirely consistent with Mr. Hubbard's Executive Letter, and consistent also with their previous dealings with journalists who have written about them. A Toronto journalist was similarly attacked after publishing an article on Scientology, and he has concluded that representatives of this group "can be fanatic, paranoic, cruel, vindictive, and intolerant".²¹

Because our information in certain aspects of Scientology remained incomplete in spite of our previous attempts to secure their cooperation, the Committee felt it had no alternative but to issue a further subpoena requiring the group to produce certain factual material. Representatives of the Church of Scientology appeared before the Committee for a hearing on December 10, 1968. Again they refused to answer questions or to produce the information requested. They said that they refused to answer on the grounds that 1) they were a religious group, and 2) they were not engaged in the healing arts.

The Committee, however, is satisfied that the Church of Scientology does in fact attempt to engage in healing, and makes explicit claims to heal. We cite here a brief selection of the available evidence, which is presented more fully in Lee's report, all of which are taken from official Scientology publications.

With Dianetics it became possible to eradicate aberration and illness because it became possible to nullify and eradicate the pain from the pain storage banks of the body without applying further pain as in surgery. Arthritis of the knees, for instance is the accumulation of all knee injuries in the past. The body confuses time and environment with the time and environment where the knee was actually injured, and so keeps the pain there. The proof of this is that when the knee injuries of the past are located and discharged, the arthritis ceases, no other injury takes its place and the person is finished with arthritis.²²

Tens of thousands of case histories (reports on patients, individual records) all sworn to (attested before public officials) are in possession of the organizations of Scientology. No other subject on earth except physics and chemistry has had such gruelling testing (proofs, exact findings). Scientology in the hands of an expert can cure some seventy per cent of man's illnesses (sicknesses).²³

One particular and specialized method of application is its use on individuals and groups of people in the eradication of physical illnesses deriving from mental states.²⁴

From the Toronto Scientology newsletter, 1965, in an article entitled "The Scope of Scientology, the Need to Change", we find the following:

²¹"That's What Scientology is All About", *The United Church Observer*, December 1, 1968 p. 40.

²²L. Ron Hubbard, *Self-Analysis*, The International Library of Arts and Science, 1951, pp. 17-18.

²³L. Ron Hubbard, *Scientology, the Fundamentals of Thought*, The Founding Church of Scientology, Continental, Hubbard Scientology Organization for the Eastern United States and Canada, Washington, D.C., 1956, p. 10.

²⁴*Ibid.*, p. 51.

Of what must science of mind be composed?

1. An answer to the goals of life.
2. A single source of all insanities, psychoses, neuroses, compulsions, repressions, and social derangements.
3. Invariant scientific evidence as to the basic nature and functional background of the human mind.
4. Techniques, the method of application, by which the discovered single source could be invariably cured, ruling out, of course, the insanities of the malformed, deleted or pathologically injured brains or nervous systems and particularly, iatrogenic psychoses (those caused by doctors involving the destruction of the living brain itself).
5. Methods of prevention of mental derangement.
6. The cause and cure of all psycho-somatic ills, which number, some say, 70 per cent of Man's listed ailments.

Simple, though it is, Scientology does, and is doing, and is, all these things.²⁵

Although representatives of Scientology have argued that the writings of Mr. Hubbard are no longer to be considered the basic doctrine of the Church, we note that the books and writings of Mr. Hubbard are prominently on display for sale in offices of the Church and that it is expected that everyone interested in, or a member of the Church should read these writings.

We also note that one of the objectives of the Church, as taken from "The Certificate of Incorporation of the Church of Scientology", February 1954, California, is

... to practise its teachings and beliefs, and to propagate, in accordance with its tenets, healing of the sick and suffering by prayer or other spiritual means without the use of drugs or material remedy.

Scientology has been investigated in several other jurisdictions. An official investigation in the State of Victoria, Australia, conducted in 1965 by Mr. Kevin Anderson, Q.C., reported that:

The official attitude advanced at the Inquiry that Scientology did not claim to heal was, and is, only a camouflage. The real intention of Scientology is to inculcate in the minds of anyone who becomes interested in it the impression or belief that, as well as being a panacea for all problems, worries, and aberrations, it is a gateway to sure cures for a great variety of mental and physical ills. And it is at the very basis of Scientology teaching that mental and physical well-being is assured to those who have sufficient Scientology processing.²⁶

On the basis of that inquiry, the Psychological Practices Act, 1965, was passed by the State of Victoria, prohibiting "the teaching, practice or application of Scientology" for fee or reward. A similar bill was introduced into the South Australian Parliament in September 1968, after a joint meeting of the Ministers of Health of all the Australian states at which they resolved to keep a watchful eye on the activities of Scientology.

²⁵*Viewpoint*, Vol. I, No. 4, 1965, p. 7.

²⁶*Report of the Board of Inquiry into Scientology*, Victoria, Australia, 1965, p. 119.

Evidence available from Great Britain also is instructive. In Britain an inquiry into Scientology made by the Home Office and the Ministry of Health concluded that the practice of Scientology was not in the public interest and proved in many cases dangerous to its adherents. In July 1968, steps were taken by the government under the Aliens Order to restrict the entry of foreign nationals who wished to study at the international Scientology headquarters. Scientology centres were to be no longer recognized as educational establishments, and no entry visas for the purpose of study would be issued to foreign Scientologists.²⁷ On January 27, 1969, Mr. Crossman, the British Minister for Social Services, announced in the House of Commons that an inquiry would be conducted into "the practice and effects of Scientology". The existing restrictions on foreign students would continue during the inquiry.²⁸

In the United States, however, the efforts of the federal Food and Drug Administration to have the E-meters declared a misbranded medical device were thwarted by a February 1969 decision of the U.S. Court of Appeals, reversing a Federal Court decision. The Federal Court had accepted the Food and Drug Administration's contention that false and misleading therapeutic claims were made for the device, but the Court of Appeals ruled that the E-meter and literature accompanying it was protected from seizure by the right of freedom of worship, until it was proved that Scientology was not a religion.

A recent decision (November 1969) of the Queen's Bench Division in England, whose judgments are usually considered more relevant to the law in Ontario than American judgments, held that the chapel of the Church of Scientology of California at their headquarters at East Grinstead, Sussex, ought not to be registered as a place of worship under the Place of Worship Registration Act, 1855, because it was "difficult to reach the conclusion that it (Scientology) is a religion".²⁹

Having carefully considered the available evidence, the Committee concluded that the theories and practices of the Church of Scientology do in fact place it within the purview of the Committee, and that scientologists do purport to heal.³⁰ Faced with the refusal of the Scientologists to provide information and with their challenge to our jurisdiction as a Committee of Inquiry, we had to decide whether to exercise our powers in order to proceed with further inquiries. We decided somewhat reluctantly that it was pointless to go any further; we already possessed more than sufficient evidence from a variety of sources to enable us to make informed and reasonable judgments concerning the Church of Scientology. Because — as we have indicated — Scientology is an international organization, the beliefs and practices of which are common to many jurisdictions, and because the Toronto group has no substantial degree of independence from the parent

²⁷See Written Answer No. 1459/1967/69, July 25, 1968, House of Commons.

²⁸*The Times*, January 28, 1969, p. 6.

²⁹*Regina vs. Registrar General, Ex Parte Segerdal and another. The Times*, November 15, 1969.

³⁰In November 1969, some months after this chapter was written, the Church of Scientology in Toronto advertised a "Crusade for a Healthy Canada Through Dianetics".

body, the information available to us from the intensive investigations elsewhere, particularly Australia and Great Britain, and our study of the internationally published literature provided us with most of the information which we required.

We had already adopted the position stated in Chapter 1 that there was a point beyond which we would not go in restricting the rights of mentally competent individuals to seek treatment from health practitioners of their own choice, unless we found evidence that the practice might be harmful, in the sense discussed in Chapter 1. We did not believe that the compilation of further evidence pertaining to Scientology would be likely to cause us to recommend the prohibition of its practice in Ontario and so we did not consider that the additional information which we might obtain would be of a nature to justify the further expenditure of time.

We wish to make it very clear, however, that we believe that the Church of Scientology should not be excluded from the proscriptions of the practice of medicine under the Medical Act on the grounds of being a religion, and that the public authorities in Ontario should be aware of the history of this organization in other jurisdictions and should keep the activities of Scientology under constant scrutiny.

General Conclusions

The Committee has found little evidence to suggest that there exists a high or growing demand for the services of sectarian healers. Indeed we have little or no evidence at all concerning numerical utilization of the services of sectarian healers. Apparently the great majority of the public habitually resort to medical and other professional practitioners for their health care. Nevertheless, there are demonstrable reasons for the existence of sectarian healers who fulfil real, if marginal, functions in society. Their work should be seen in relation to many related problems of the entire complex of health services.

It must be borne in mind that many physical illnesses may be "cured" by spontaneous natural processes. "Nature" remains one of the most efficient healers of many ills. That many sectarian healers apparently accomplish remarkable cures is undeniable; it may be equally true, but impossible to prove, that many of these apparent "cures" might otherwise be effected by entirely natural processes. We are much too conscious of the limitations of human understanding to hazard pronouncements upon the curative powers of either sectarian healers or nature.

More important, we are aware that the existence of untrained or partially trained sectarian healers may render to patients a highly questionable quality of health care, and that the quality of the health care in the whole health system may thereby be diminished. On the other hand, we are also aware that such sectarian healers have always existed and may always be expected to exist. Apparently there are certain sections of the public which continuously desire and seek out sectarian healers emphasizing healing by suggestion. The reasons why this should be true are conjectural, but they appear to include the following factors: 1) shortages

of medical practitioners; 2) the high cost of modern health care provided by more orthodox practitioners; 3) the inability of modern medical science to cope adequately with many problems of chronic disease; 4) the failure of many practitioners to find sufficient time to consider adequately the emotional and social factors of disease and emotional unease, as well as the real need of many patients for reassurance and spiritual counsel in times of distress and illness; 5) the inadequacy of public health education, and the consequent inability of many patients to make entirely rational decisions as to what type of health care should be sought.⁸¹

For these reasons it should not be surprising that such a wide variety and sizable number of sectarian healers continue to offer their services to certain sections of the population. Viewed in this perspective, it may be reasonable to assume that in an imperfect human society there will always be some demand for the services of suggestive therapists. It may also be reasonable to assume that advances in scientific health technology, improvements in the delivery system of health services, and the development of higher standards of public health education accompanied by higher levels of general education, may all lead to a gradually declining demand for the services of suggestive healers in the future.

But whether the demand for such services increases or decreases in the future, we are not persuaded that unusual impediments should be placed in the way of citizens seeking to give or receive the suggestive therapies discussed above. This Committee has no wish to make recommendations which would be excessively paternalistic. In general, consumer sovereignty should not become more restrictive than it is unless there exists good and sufficient evidence on which to base such new restrictions.

Nevertheless, the field of health services is not one in which a policy of complete laissez-faire does or should obtain. The right of the public to choose a practitioner must be limited in some degree by a regard for the protection of the public interest. Consumer sovereignty has never been absolute in the field of health. The services of healing practitioners cannot be regarded as a simple commodity, like soap or automobiles, in relation to which it can always be assumed that the consumer is possessed of sufficient information enabling him to make rational choices. Extremely rapid and complex advances in healing technology during the past century have confronted the layman with a wide variety of specialists within the health industry and a baffling array of choices between which he cannot always make an informed selection. In many jurisdictions, including Ontario, significant limitations on consumer sovereignty in the health field already exist. Through delegation of powers to professional bodies, government does place restrictions on various healing disciplines by the implementation of licensing and certification procedures over most of the healing disciplines; and in the senior professions at least, unlicensed

⁸¹Compare the section on sectarian healers in *Medical Care in Transition*, Vol. 1, U.S. Department of Health, Education and Welfare, Washington, D.C., 1964, p. 25.

personnel are not permitted to practise. It has long been recognized that the individual has no "right" to spread communicable disease to other members of the community. Further protection to the public traditionally has existed through laws which protect the citizen against conduct amounting, for example, to criminal negligence. Thus the right to practise the healing arts has always been subject to limitations, and the rights of patients to select practitioners also have been subject to certain limitations in the public interest.

If further limitations are to be contemplated with regard to sectarian healing, we must ask ourselves, at least, if there is evidence that the practice of sectarian healing presents any real danger to the community and the total health system.

Neither Lee's study nor this Committee's own inquiries disclosed the existence of any grave degree of demonstrable harm (as discussed in Chapter 1) to the health system or the general public as a direct result of the activities of sectarian healers. No cases have come to our attention in which sectarian practitioners or their adherents have violated Ontario's public health laws and thereby endangered the general health of the community. Accordingly, we do not believe that any general prohibition or major legislative change to protect the community is warranted in this area.

It is, of course, possible that adherents of sectarian groups may rely excessively or exclusively on suggestive therapy, and thereby delay seeking orthodox professional services or fail to resort to such services at all. Even if higher rates of morbidity and mortality among those resorting to sectarian healers' help were convincingly demonstrated, that in itself would not be reason enough to require changes in legislation which would involve compulsion. For example, many citizens neglect preventive health measures and fail to obtain annual medical or dental check-ups. In a free society, there are significant limits to state paternalism and compulsion.

Nonetheless, we would be evading the issue if we failed to make any pronouncement upon the "merits of the practice" of sectarian healing. In general this Committee remains skeptical of the healing capacities of sectarian practitioners and does not believe that their services are meritorious or of proven quality. But in trying to assess the quality of health care delivered by sectarian healers, clearly we are dealing with an area in which measurement or quantification is impossible. Lee's study discovered little or no evidence that the physiological health of adherents suffers by reason of their relative disinclination to resort to the services of physicians or other professional practitioners.

Since our investigations have not discovered any degree of demonstrable harm either to individual patients or to the general public, we conclude that no particular legislative inhibitions on the activities of sectarian healers would be appropriate. The traditional right of mentally competent adults to resort to the practitioner of their choice should be preserved.

Our concern to impose reasonable limits on governmental paternalism by, for example, underlining the right of the citizen to receive the services of the practitioner of his choice is evident throughout this Report. This right, however, like all rights, is not unqualified. Society has an interest in preventing the practice of an art where that practice produces harmful consequences to individuals. The possibility of producing harm does not in our view justify the prohibition of the practice; effecting of harm does. Where there is evidence of a minimal amount of harm the two interests, the right to freedom of choice on the one hand and the interest of society in preventing harm on the other, must be weighed. Where the harm is real but, on the whole, insignificant, and this is always a question of judgment, it is our view that the freedom of choice should not be sacrificed. Where the harm is real and significant, the interest of society in preventing harm should not be sacrificed. But behind all this we must recognize that there has always been and, we believe, should always be, a realization that not all members of society are competent to make the decision or render the judgment involved in the exercise of free choice. A special protection must be given to the mentally incompetent and to children.

Limiting our discussion for the moment to children, we do not acknowledge that the right to select a particular kind of practitioner includes the right to select him for one's child. Society's traditional concern for the welfare of children as paramount over the rights of the parents, as recognized in the ancient concept of the king as "*parens patriae*", will not, and we think must not, permit a child's parents whose religious or philosophical beliefs conflict with conventional medical practice to choose an unorthodox practitioner where the child's life or health may be endangered. In recommending that surveillance should be kept over the practices of the various sectarian healers, as we indicate below, we particularly have in mind the health of children. But apart from such surveillance, we do not think that existing legislation is deficient or needs augmenting. Relevant provisions of the Criminal Code of Canada which impose a duty on a parent to provide children with the necessities of life,³² which, it is clear,³³ include medical care, and Part II of the Child Welfare Act, 1965, c. 14, are adequate for the task of protecting children. Under these provisions care of the child by his parents or guardians may be made subject to the supervision of the Children's Aid Society; or the child may be made a ward of the Children's Aid Society, or of the Crown where he is found to be a child in need of protection. A "child in need of protection" is defined³⁴ as "a child where the person in whose charge he is neglects or refuses to provide or obtain proper medical, surgical or other recognized remedial care or treatment necessary for his health or well-being, or refuses to permit such care or treatment to be supplied to the child when it is recommended by a duly qualified medical practitioner, or otherwise fails to protect the child adequately".

³²R.S.C. 1952, c. 51, particularly s. 186.

³³See, for example, *The King v. Brooks*, (1902) 5 C.C.C. 372 and *Rex. v. Lewis*, (1903)

6 O.L.R. 132.

³⁴S.O. 1965, c. 14, s. 19 (1) (b) (x).

Our decision not to formulate recommendations restricting the practice of sectarian healing should not be construed as indicating any profound conviction that no problems for public policy exist in the realm of suggestive therapy. Our investigations have led us to believe that what healing powers these groups have are marginal; and while we do not deny that they have provided some benefit to some persons, on balance they probably have little to offer in the whole scheme of the healing arts. At the same time, the Committee cannot recommend they be included under any medical insurance coverage. We recognize that, in the absence of a specific definition of the practice of medicine under the Medical Act, temptations may exist for some sectarian and other healers to disseminate misleading advertising making claims to cure certain diseases which cannot be substantiated; but we believe that laws governing fraud under the Criminal Code presently provide adequate protection to the public. Nonetheless, we believe that continued vigilance over and scrutiny of sectarian healers, as well as all other professional and non-professional healers, are desirable. This scrutiny should be maintained by the Department of Health. Special problems may deserve attention concerning the practice of one particular and relatively sophisticated form of healing by suggestion, the practice of hypnotherapy.

Hypnosis and Hypnotherapy

Definition

The term "hypnosis" covers both an induced condition and the technique by which it is induced. Although an exact definition of hypnosis has never been agreed upon by all the experts in the field, enough is known about the nature of hypnosis to disprove the popular misconception of it as a form of "black art" used by unscrupulous manipulators to force unwilling victims into actions beyond their control. Certainly there are many dangers inherent in the use of hypnosis; but as a therapeutic tool it has many legitimate medical uses.

The first known use of hypnosis was therapeutic, in Egyptian and Greek temples of healing where it was called "temple sleep". The occult reputation of hypnosis that still lingers on, however, dates from its association in the eighteenth and nineteenth centuries with theories of animal magnetism and with stage performances. Franz Mesmer's "magnetic" form of healing, developed in the 1780's, was the first non-religious application of hypnotherapy, but the occult trappings of his technique led to his denunciation by French scientists. Not until 1882 did the French Academy of Medicine recognize the medical value of hypnosis, and medical associations in the English-speaking world took three-quarters of a century to follow suit. Since hypnotic techniques are quite easy to learn, hypnosis became a popular form of stage entertainment, and some stage hypnotists applied their skills to the healing arts to become lay hypnotherapists.

The Report of the Canadian Medical Association Special Committee on Hypnosis has described the actual hypnotic state as follows:

Its principal psychological features consist of a narrowing of consciousness and an increase of suggestibility, while the main physiological alternation in the hypnotic state may be found in an increased liability of processes regulated by the autonomic nervous system.³⁵

Achievement of a hypnotic state and the depth of the trance produced depend upon the suggestibility of the subject. Suggestibility is not a constant state, but varies among individuals and with the individual according to his physiological and psychological condition. Some subjects will go into a hypnotic state after only a few words from the hypnotist; others may remain completely uninfluenced by any hypnotic technique.

Dangers of Hypnosis

It must be emphasized that hypnosis is a technique which increases the suggestibility of the subject, not a form of therapy in itself. While the subject's basic standards probably place a limit on the suggestions which can be introduced to him under hypnosis, nevertheless, the Canadian Medical Association Committee on Hypnosis reported that:

It is generally accepted that the psychodynamic aspects of hypnosis involve a regression to a more primitive, dependent behaviour, diminished critical judgement and loss of a considerable degree of initiative, as well as emotional disinhibition resulting in an increased accessibility to repressed and suppressed material.³⁶

The value of any therapeutic use of hypnosis depends both on the skill in using hypnotic techniques of inducing suggestion and the competence in the area of therapy in which the technique is applied. Thus lay hypnotherapists, untrained in psychology or other recognized academic disciplines of the healing arts, may do more harm than good. Hypnotic interference with one aspect of the mind may affect another aspect of physical or mental health. There is a danger that certain spontaneous phenomena such as amnesia or catalepsy may occur without being suggested, or that hypnotherapy may be used to treat the symptoms of an unrecognized organic disorder that the hypnotist is unqualified to diagnose.

In fact, there appear to be few documented cases of harm arising from the use of hypnotherapy, but the possible harmful effects of hypnotherapy have led both the Canadian and American Medical Associations to recommend that hypnotherapy be used only by physicians, dentists and psychologists trained in the basic principles of psychiatry and in the use of hypnosis, and only after an adequate physical examination.

Hypnosis is recognized today by the medical associations of many countries, including Canada, as a valuable technique to aid therapy, within the limits mentioned above. Despite the official sanction, however, few physicians do use

³⁵*Report, Recommendations on Hypnosis, Special Committee on Hypnosis, quoted in the Canadian Medical Association Journal, November 16, 1963, p. 1045.*

³⁶*Ibid.*, p. 1045.

hypnosis. A sample survey of Toronto physicians conducted by Lee revealed that only 3 per cent of those replying had any training in hypnosis, but a further 9 per cent had at some time referred a patient for hypnotherapy.³⁷ No formal training is given in hypnosis in Canadian medical schools, although discussion and demonstrations of hypnosis are frequently part of psychology or psychiatry courses.

Three Toronto hypnotherapists were examined in the study prepared for the Committee. The three lay hypnotherapists operate according to Regulation 353/61 under the Hypnosis Act,³⁸ which permits lay practitioners to remain in practice if they practised hypnosis for a period of five years before the first day of January, 1961, and earned an average of \$2,500 a year from the performance of hypnosis during that five-year period. The legislation does not set out any minimum training qualifications for lay practitioners. One Toronto practitioner has a B.A. in psychology from the University of Toronto; another has several degrees from an unaccredited university and has had over 600 hours of training in hypnosis; and the third practitioner entered lay hypnotherapy after working as a stage hypnotist, and holds no degree.

The claims of the practitioners vary with the individual, but they all advertise relief of social, marital and sexual problems, and specific problems such as insomnia. Most clients refer themselves to the hypnotherapist, although a few are referred by a physician, minister or psychologist. All three hypnotherapists stated that they always ascertained that new patients had a recent medical examination; however, Lee found two cases in which patients positively confirmed that no such question had been asked of them.³⁹

Generalizations cannot be made about the therapeutic techniques of the three practitioners. One, who is also a pastoral counsellor, emphasizes counselling and does not use hypnosis on all his clients. When he does, a device called a Brainwave Synchronizer helps induce a hypnotic state. Another uses no aids to induce hypnosis, while the third favours the use of tranquilizing drugs by clients to assist induction by sleep-talk.

No formal complaint has been laid against any of the practitioners with the police or any agency, although one complaint has come to the Committee's attention concerning a practitioner submitting a patient to narcoanalysis without the patient's consent.

Training in Hypnosis

As noted above, formal instruction in the technique of induction of hypnosis and the framing of suggestions is not taught in medical schools in Ontario. Instead, most hypnotists have learned their methods from other experienced hypnotists. Some hypnotists set up "institutes" or "colleges", operating under government

³⁷John A. Lee, *op. cit.*, p. 18.

³⁸R.S.O. 1960-61, c. 38.

³⁹John A. Lee, *op. cit.*, p. 27.

charter as private institutions, which grant "degrees" such as "Registered Hypnotist" or "Licensed Hypnotist". Two such institutes are the College of Somnotherapy and Psychology in London, England, and the School of Applied Hypnology in New York City. One of the Toronto hypnotherapists runs his practice as an "Institute" and claims to train physicians, dentists and others in hypnotic techniques.

Several American associations have been organized to protect and promote the professional practice of hypnosis. One of these, the American Society of Clinical Hypnosis, is a body of professionals only, and has the respect of the medical, psychiatric and psychological professions. Others, such as the Association for the Advancement of Ethical Hypnosis, have rather low minimum standards for membership and include lay hypnotherapists and stage hypnotherapists.

Regulation of Hypnosis

The Ontario legislation regulating hypnosis, the Hypnosis Act, 1960-1961, subtitled *An Act to Protect the Public from the Use of Hypnosis by Unqualified Persons*, forbids all hypnosis, thereby including its use by private individuals on family or friends, except in the cases of qualified medical practitioners and registered dentists in the practice of their profession; registered psychologists using hypnosis at the request of or in association with a legally qualified medical practitioner; and supervised students of one of these professions. As mentioned above, a regulation made under the Act permits lay practitioners to continue in practice if their income from hypnosis averaged \$2,500 per year in the five years prior to 1961. Neither the Act nor the regulations require that physicians, dentists and psychologists have special training in hypnosis, or that lay practitioners fulfil any minimum academic or training standards.

Lee found that hypnosis and hypnotherapy are directly regulated in only three other jurisdictions, two American states and one Australian state. The Florida hypnosis law limits hypnotherapy to practitioners of the healing arts or persons under the supervision of practitioners of the healing arts. (The healing arts are defined as the practice of medicine, surgery, psychiatry, dentistry, osteopathic medicine, chiropractic, naturopathy, podiatry, chiropody and optometry.) A certificate is required to practise hypnotherapy in Ohio, obtainable after successful completion of a course in medical science. The Victoria Psychological Practices Act limits the use of hypnosis to persons under the supervision of a qualified medical practitioner or dentists in the course of their practice, and forbids the use of hypnosis for public entertainment or on minors.

The "physical and mental" definition of medicine used in many jurisdictions could be used to regulate by judicial interpretation the practice of hypnotherapy. A proposed California law to regulate the practice of hypnosis was deemed unnecessary because the California courts had already interpreted the practice of medicine to include hypnotherapy.

The Committee is persuaded that hypnosis can be a therapeutically useful tool when the conditions under which it is employed are carefully controlled. We

cannot regard the present requirements under the Hypnosis Act for the practice of lay hypnotherapists as providing sufficient or conclusive proof of competence in the use of hypnosis, nor do we believe that lay hypnotherapists should be permitted to treat patients on other than a referral basis.

Although the Committee has discovered no instances of serious harm resulting from first contact treatment by lay hypnotherapists, it cannot be denied that lay hypnotherapists are unqualified to recognize serious organic diseases, the symptoms of which may occur in the form of minor ailments such as insomnia or headaches. Lee's study indicated that not all patients of lay hypnotherapists had received recent medical examinations. While we believe that persons skilled in the techniques of hypnosis induction may be useful, if not numerically significant, participants in the health delivery system, we also believe that hypnosis technicians must provide to the appropriate licensing authority adequate proof of formal training before being permitted to practise, and should work only under the direction of, or on referral from, a registered physician, dentist or clinical psychologist.

Accordingly, we favour amendments to the Hypnosis Act to establish a licensing system for all persons who wish to practise hypnosis. As in the existing Act, however, all physicians, dentists and clinical psychologists registered under the appropriate Acts would be permitted to use hypnosis in the practice of their professions if they so desired. The licensing system should be administered by the Health Disciplines Regulation Board proposed in Chapter 25 of this Report, and this body should determine the standards required for licensure as a hypnosis technician.

Evidence from medical authorities and from Lee's study indicates that few physicians do use hypnosis in the course of their practice. While one reason for the infrequent utilization of hypnosis may have its basis in the lingering "occult" reputation of hypnosis, another reason may arise from a lack of opportunity for students in medical and dental schools to learn the techniques and uses of hypnosis in relation to the specific branch of the discipline in which they are specializing. We wish to encourage all efforts on the part of Ontario medical and dental schools to make available to students courses in the use of hypnosis.

Recommendation:

- 292** That the Hypnosis Act be amended to establish the category of hypnosis technician, and that all persons, with the exception of registered physicians, dentists and clinical psychologists, but including those who presently practise hypnosis by virtue of Regulation 353/61 under the Hypnosis Act and who wish to use hypnosis, be required to obtain a licence as a hypnosis technician from the Health Disciplines Regulation Board, and that licensed hypnosis technicians practise only on referral

from physicians, dentists and clinical psychologists. The standards for licensing of hypnosis technicians should be established by the Board through a Division for hypnosis technicians, but the level of educational requirements for licensure should be similar to those required of technical personnel rather than those demanded of professional personnel.

Minority Opinions

Minority Opinion on Chapter 9, Dentists and Dental Care Personnel, Recommendation 56

I do not believe that we are justified in recommending a third faculty of dentistry in Ontario on the basis of the evidence available to us. I believe that instead our recommendation should be "that a thorough study be made of the need — current and projected — for dental care services in Ontario, with particular reference to the kind of services, the manpower requirements to supply these services, and any measures that may be necessary to meet such manpower requirements". Such a recommendation would, I believe, be more consistent with the position which we take in Chapter 24 regarding the analysis of health care requirements which should precede and be the basis of all planning for the delivery of health services.

Such a study, which would go further than we have been able to go, must examine in what way the present mix of dental services available in Ontario could be improved in the public interest and, if supplementation is required, what kind of services should be added. Obviously it should take into consideration the effect on the demand for dental services of such changing circumstances as increased education of the public in the need for dental care, improved distribution of dental care in underserved areas, and the possible coverage of dental care services by OHSIP.

In evaluating the merits of the different types of services which might be extended if supplementation is required, particular attention should be paid to the respective merits of preventive services as opposed to restorative services and to the relative cost of developing the auxiliary personnel who are capable of providing much of the former as compared to the cost of producing dentists whose skill is required for the latter. In making this evaluation there is much to be learned from the experience of countries such as New Zealand and the United Kingdom, each of which dealt some years ago in different ways with the problems which may be facing us in Ontario now. While the structure of the service varies from one country to another, in both of them the emphasis has been on preventive dentistry and on the development of dental auxiliaries to handle preventive procedures and to improve the utilization of the time and the skills of the qualified dentist.

The dental profession in Ontario has been reluctant to move in this direction and as a result we have no auxiliaries like the New Zealand or U.K. dental nurse, while the output of hygienists — the product of two-year courses at our university dental schools — is much smaller than the output of dentists from the same schools.

This situation must be re-examined before the decision regarding a third faculty is taken, because it involves considerable expenditure both to create the facility and to subsidize its operation. The wrong decision taken prematurely would be contrary to the public interest, not only because of the injudicious application of scarce resources, but because it would almost certainly harden the attitude of the dental profession towards more extensive employment of auxiliaries. A dental profession increased in numbers, or anticipating an increase in numbers relative to the population, would be likely to be more opposed to the extension of the use of dental auxiliaries than it has been in the past. An increased number of dentists might have more time for preventive measures than dentists have today, but this would be inefficient use of a dentist's skills and an uneconomical investment of resources which it is decided should be applied to prevention.

I. R. DOWIE

Minority Opinion on Chapter 10, Nursing, Recommendation 75

I have to disagree with Recommendation 75 because I do not believe at this time that we can be certain that such a change is in the public interest.

Chapter 10 reflects the confusion which exists in nursing, the uncertainty as to education and the roles of nurses which affect the relationships of groups within nursing and of the nursing profession with other disciplines and with employers of nurses.

Many of the problems of nurses which are discussed in this chapter are appropriate subjects for collective bargaining between employer and employee. Such bargaining is taking place freely between nurses and hospital administration under present legislation and no change would seem to be necessary to accommodate it. Other problems involving questions of the role of nursing, internal relationships in nursing and the relationship of nursing with other disciplines which have, as Murray points out, frustrated nurses for many years might well become subjects for collective bargaining if the RNAO were to be recognized as the bargaining agency for nursing province-wide.

The studies which should be made of these problems and the manner in which they are solved will have a profound influence on the quality and possibly the quantity of nursing service in Ontario and so it is most important that they be solved in the way that best serves the public interest and not on the basis of bargaining strength.

There has been no suggestion made to us by the nursing profession or by anybody else that the RNAO would bring such matters to the bargaining table, but obviously this and other problems could develop; and so I do not wish to recommend any amendment of legislation which would facilitate such a development at this time and might even be construed as an endorsement of it.

I think we indicate in Chapter 10 that we are aware of these problems and the effect which they can have on nursing services. A number of the recommendations which we make are designed to direct attention to them and suggest ways in which they might be approached.

Apart from the recommendations in Chapter 10, we have recommended in Chapter 24 that the solution of such problems should no longer be left to the disciplines involved but should be undertaken by a body which has a responsibility for the coordination of the activities of the various disciplines working together in

a health services system. I believe that the measures proposed in Chapter 10 and the intervention of a coordinating body should be effective in solving these problems and I believe that it is very much in the public interest that they should be solved in this way.

I. R. DOWIE

Minority Opinion on Chapter 11, Pharmacy, Recommendations 107, 108, 109, 112, 113, 114, 119, 124

I do not agree that a second faculty of pharmacy should be established at an Ontario university as proposed in Recommendation 107 because I do not believe that enough is known about the reported shortage of pharmacists in Ontario or the kind of education they require for their greatly altered role. The pharmacists themselves agree that studies should be made of these and other questions and told us that a study was presently being made to define 1) the occupational role of the pharmacist, 2) the structural and manpower needs of the profession, 3) the educational requirements, 4) student recruitment, selection and academic performance versus professional performance. This study was initiated some years ago but progress has been very slow because of lack of funds. Any decision regarding a new faculty should await the completion of this study or some other adequate analysis of the requirements.

Also relevant to the consideration of a recommendation for an additional faculty are the views endorsed by the Committee of Presidents of Universities of Ontario in June 1966 that basic pharmacy education should be removed from the university. The President's Research Committee said "before undertaking new university programs in this field the professional training experiments should be carefully re-examined in terms of the future role of the pharmacist in the delivery of health care in the community" and also "it is doubtful that additional undergraduate expansion at the university level beyond that projected at the University of Toronto is required. It is reasonable to expect that different types of training programs for pharmacists will emerge and that some of these may be managed effectively in other post-secondary institutions."

Although we were told by the Ontario College of Pharmacy that "it does . . . appear that at the present time there is no serious shortage of pharmacists in Ontario in the field of community pharmacy", I believe that a projection of manpower requirements will show that some additional source of qualified pharmacists will be required in Ontario in the future, particularly if the requirements regarding the employment of registered pharmacists in hospitals are made more stringent as the pharmacists propose they should be; but I do not believe that there is any basis at this time for a decision to proceed immediately to provide such a facility in a university.

One of the great problems in endeavouring to assess the need for additional pharmacists is that pharmacists engaged in retail pharmacy spend a great deal of

their time in doing things which do not require their pharmaceutical qualifications. This is shown in the 1962 survey conducted for the Hall Commission, which found that 45 per cent of the retail pharmacists spent less than one-quarter, and 33 per cent between one-quarter and one-half of their working time filling prescriptions,¹ and these figures were confirmed by an unpublished study made for this Committee. The larger the establishment and the greater the volume of dispensing business which it handles the more efficient is the utilization of the skills of the pharmacist, and possibly because of this factor the trend is to larger units and to pharmacies specializing in dispensing. From the point of view of the optimum utilization of resources, then, it would seem that this trend should be encouraged, and the potential improvement which it offers in the utilization of pharmaceutical skills is one of the factors that makes the "shortage" of pharmacists controversial. On the other hand, a concentration of pharmaceutical services in large units would be likely to influence unfavourably the distribution of these services, working a hardship on some consumers who might have long distances to travel to obtain their pharmaceutical requirements.

In appraising this hardship it should be borne in mind that the trend in retail businesses in general is to larger units in shopping centres, so that were it not for the urgency with which pharmaceutical services are sometimes required this development could be viewed with equanimity. Even so, it is possible that on the whole the public would be better served by centrally located large dispensing units than by dispersed small units if the larger units remained open for longer hours than small units customarily do. There are, however, in rural Ontario, and even in the environs of major cities, areas which could not support large units employing a number of pharmacists. Such communities depend on smaller units which are frequently operated by the pharmacist-owner alone or assisted by another pharmacists. The great problem for such units is that the hours during which the public requires prescription service are too long for one pharmacist and yet the volume of dispensing requires only a fraction of his time. For such units the employment of another qualified pharmacist, whom we are told must sometimes be paid more than the owner is able to pay himself out of the business, is likely to be uneconomical.

For the relief of the operators of such outlets, it is proposed in Recommendation 108 that the professional section of the pharmacy should be segregated from the rest of the premises and that only the professional section need be closed when the registered pharmacist is not on the premises. The disadvantage of this concession is, of course, that to the extent that the pharmacist avails himself of it the service to the public deteriorates through the reduction of hours when prescription services are available. The pharmacist argues that this disadvantage is offset by the fact that this concession will enable some marginal neighbourhood stores to remain in business thus averting a deterioration in distribution, and also that the

¹*Royal Commission on Health Services*, Vol. II, Queen's Printer, Ottawa, 1965, p. 31.

relief from the need to engage a second shift pharmacist means that that pharmacist, whose skills would have been inefficiently utilized in such an outlet, is available to work elsewhere where his time may be better employed. These points have considerable merit and it may be that they do outweigh the disadvantages.

It would be my suggestion that a pharmacy wishing relief in this respect should obtain the endorsement of the "District Health Services Board"² and apply to the Health Facilities Board for a special permit to operate in this matter. This permit to reduce the dispensing hours while remaining open might be granted to enable a small community pharmacist to devote some of his time to the local hospital pharmacy, but it would seem that a happier solution in communities where such measures are necessary would be for the retail outlet to be located on or close to the hospital premises so that the pharmacist would be available to serve both the hospital and the community during the full extent of a working day. Such an arrangement, which already exists in Sarnia³ and possibly in other communities, would improve the utilization of the time of the pharmacist and possibly reduce the cost to the hospital of retaining the services of a registered pharmacist.

A peculiarity of the present law is that while retail pharmacies may only remain open as long as a registered pharmacist is on the premises, hospitals may operate pharmacies and are not required to employ a registered pharmacist. The pharmaceutical organizations which appeared before us urged that the law be amended to require that hospital pharmacies must be supervised by a registered pharmacist, but Recommendation 109 opposes this proposal. We discussed this question with the representatives of the Ontario Medical Association, the Ontario Hospital Association, and the Ontario Hospital Services Commission, who appeared before us, and also with the pharmaceutical bodies; and we heard no justification of the present situation from any of these bodies other than that if all hospitals were required to have registered pharmacists, there would not be enough to go around. This means simply that a quality control and safety measure considered so important for the retail business that the pharmacy must be closed when the pharmacist leaves the premises is being waived altogether in the case of hospitals because it is inexpedient. I disagree with Recommendation 109, and I recommend that hospitals be required to retain the services of a registered pharmacist but be given a reasonable period of time in which to comply. I think it would be sufficient to require that the hospital pharmacy be "under the direction of a registered pharmacist" provided that the hours during which the pharmacist attended the hospital pharmacy were sufficient to justify his responsibility for the operation, and that responsible health authorities were satisfied that the system of handling drugs in each hospital was such that twenty-four hour attendance of a registered pharmacist would not be necessary.

²A local body recommended in the minority opinion in Chapter 24.

³Operated by Gregory A. Hogan, Phm.B., Hogan Pharmacy Ltd., Sarnia, Ontario.

Small or remote hospitals for which this amendment would create particularly difficult problems should be encouraged and assisted financially to make arrangements such as we have discussed above which would locate a community pharmacy in or close to the hospital able to take care of the requirements of both community and hospital.

Proposals made in Recommendations 112, 113 and 114 were discussed with the representatives of the pharmaceutical organizations who appeared before us and we were told that, with the possible exception of very large dispensaries, there was no role in pharmacy for qualified assistants, and that where such an assistant could be employed, he could be trained on the job to do all that the law would permit him to do. This being the case, I cannot agree with these three recommendations and would suggest that they might be considered when the study of the role and educational requirements of pharmacists referred to above is completed.

I disagree with Recommendation 119, which would remove the control of pharmaceutical education from the College of Pharmacy, for the reasons which are discussed in the minority opinion on Chapters 24, 25 and 26.

I do not concur with Recommendation 124 and recommend to the contrary that section 34 of the Pharmacy Act be repealed because it may well inhibit desirable trends in the development of pharmaceutical services, and it cannot be shown to benefit the public interest in any significant way.

While we were urged by pharmaceutical spokesmen to recommend measures that would over a period have limited corporate ownership still further, we heard no criticism from them or from anybody else of the operation of corporate owned individual pharmacies or chains of pharmacies in Ontario.

The corporate structure in the field of pharmacy operation may easily prove beneficial in that it would accelerate the consolidation of community pharmacies into larger and more professional outlets. In view of the growing costs of establishing a professional pharmacy with an adequate inventory, the lack of initial capital may make it difficult for a younger pharmacist to acquire a pharmacy of his own, and lack of advancement possibility (other than through partnership) makes unattractive the career of a pharmacist employed by an independent pharmacy. On the other hand, the possibility of a career in a larger pharmaceutical corporation with both managerial and senior professional possibilities may prove attractive to future pharmacists. Moreover, there are economies of scale in administration, bulk buying, inventory financing and common services which will make for a healthier pharmaceutical industry and in an active, competitive situation would be likely to produce lower prices.

The fact that in five of the ten Canadian provinces there are no such restrictions on the ownership of pharmacies suggests that there is no real need for such controls.

I. R. DOWIE

Minority Opinion on Chapter 12, Optometrists, Ophthalmic Assistants and Ophthalmic Dispensers, Recommendation 138

The College of Optometry in the brief which it presented to this Committee requested that we should make such a recommendation as this on the grounds that it would help to professionalize the practice of optometry and reduce any incentive to an optometrist to overprescribe.

On the other hand, representatives of two large companies engaged in the business of selling ophthalmic appliances through retail outlets managed by qualified optometrists appeared before us to tell us that it was not in the public interest that the College of Optometrists should be empowered to declare as unprofessional conduct any markup by an optometrist on ophthalmic appliances dispensed. It should be noted that under section 11 of the Optometry Act the Board may suspend or revoke the registration of an optometrist found guilty of unprofessional conduct, as defined in the regulations.

I do not concur with this recommendation, although we have made a recommendation regarding dentists and their billing for prosthetic devices which is not dissimilar. There are, however, important differences between the two cases: the dental patient is in a sense a captive; there is no other channel through which he can obtain the prosthetic device, and any markup which the dentist charges over and above the laboratory cost to him of the device is in a sense a brokerage charge on a product which the dentist has a monopoly to handle. We took the view that the dentist was entitled to his professional fees for the prescribing and fitting of the prosthetic device, but not to a mark-up on the device.

The individual requiring vision care can proceed in a number of ways; he can go to an ophthalmologist, or an optometrist, or a variety store in which he can try on glasses until he finds a pair that suits him. If he goes to an ophthalmologist he pays the ophthalmologist a fee for the consultation and prescription which he is then free to take to a retailer, who might be an optometrist or an ophthalmic dispenser. This retailer is providing a necessary service in distributing and fitting the eye glasses. These are made of lenses bought from a laboratory and frames bought from a frame maker; and so the retailer, if he is an ophthalmic dispenser, must recover the expenses of his operation and whatever profit he can make by charging a mark-up on the lenses and frame.

The optometrist is an unusual type of practitioner, a professional man operating a retail business in which he is in competition with the ophthalmic dispenser. The

optometrist proposes to charge all his expenses and overhead including those of his retail premises to his professional practice and by charging no mark-up on the lenses and frames to appear to be conducting his retail establishment as a cost-free service to the public. To do this he has established a Schedule of Fees, which we are told,¹ permits him to charge for such items as examination, refraction, prescription and dispensing, total fees in excess of those normally charged by ophthalmologists.

If the objectives of professionalizing the practice of optometry and limiting overprescription are of great importance, they could more surely be attained by a complete divorcement of the professional practice from the retail operation, but I do not believe that this would be in the public interest because, as we have shown, the optometrists are providing necessary public services. By the same token the ophthalmic dispenser is performing a necessary public service and it is not in the public interest that he should be deprived by competitive pressures from making a fair return on his business. It seems to me that the effect of this recommendation might well be to limit his ability to do so.

The individual optometrist is already free to adopt this method of billing his customers if he pleases, and I do not suggest that he should be restricted in this freedom. On the other hand, I can see no reason why he should be obliged to do so on fear of having his conduct classified as unprofessional.

I. R. DOWIE

¹Select Optical Service Limited and the Robert Simpson Company Limited, and Simpsons-Sears Limited, Brief to the Committee on the Healing Arts, 1967, p. 16.

Minority Opinion on Chapter 15, Chiropodists

My colleagues and I agree on all the recommendations in this chapter and our only disagreement is that I believe that in our recommendations we do not make proper provision for the continuing service of the American-trained podiatrists now licensed and practising in Ontario. As a result of the recommendations set out in this chapter, this group of people would be obliged to become licensed as chiropodists under a new or amended Chiropody Act which would limit their scope of practice to "that allowed to the chiropodists in Britain".

We make our recommendation that the British-trained chiropodists be licensed here, and that a course be established in Ontario to train chiropodists to this standard, because we believe that there is a shortage of people able to do work which the British chiropodist is trained to do. At present, the only people who can do this work in Ontario are physicians and the some seventy United States-trained podiatrists; and the former do not conceal the fact that they would prefer to have someone else of appropriate competence look after people who need foot care. It is our belief that the British-trained chiropodist is competent to undertake the kind of foot care which constitutes a very large percentage of the work presently done by the American-trained podiatrist. At the same time, we are aware that British-trained chiropodists concede that they are not trained or competent to do all of the work that the United States-trained podiatrist is able to do.

The British level of training corresponds to what we have recommended for the proposed Ontario training program — that is, to a three-year diploma course at a College of Applied Arts and Technology after completion of grade twelve or thirteen. The United States schools of podiatry provide a four-year professional course following one year of college taken after grade thirteen. Because of the ambiguities of the present Ontario Chiropody Act, it is difficult to determine precisely what the difference between the competence of these two groups of foot care practitioners is understood to be, but there can be no doubt that the United States-trained podiatrist is competent to use local anaesthetics and practises a certain amount of surgery, in which field, we are told, his competence varies with the extent of his postgraduate training. Such procedures clearly lie beyond the competence of the British-trained chiropodist.

If we are correct in our beliefs that there is a shortage of foot health care services in Ontario, then it would not seem to me to be in the public interest to limit the scope of the small number of practitioners we now have to a pattern of

practice more restricted than that which they have established their competence to perform in the neighbouring states across the American border and here in Ontario.

Were there some clear evidence to show that the experience with this wider scope of practice was unsatisfactory, there would be a case for preventing U.S.-trained practitioners from providing the full range of services they are now trained to do. But the information we have obtained from American sources suggests that this is not the case. In those neighbouring states, such as New York and Ohio, where the number of podiatrists practising is as high as one to every 15,000 of population (compared to one to 100,000 in Ontario), the experience with the practice appears to have been favourable and, if anything, the acceptance of it seems to have been growing. If there are any doubts as to what the scope of the practice of podiatry should be in the future, these should be resolved by a thorough study of the experience in these American states to which I have referred and of the roles we expect foot care practitioners to perform in the overall health services scheme in Ontario. But to peremptorily rule out part of the established practice in Ontario by allowing U.S.-trained podiatrists to do no more than the British type of practitioner would mean that some persons now receiving certain kinds of foot care from podiatrists would have to try to find a physician to provide these services. In effect we would be reducing by some amount the overall supply of medical services which would otherwise be available. It is true that by adopting the British standard of chiropody, and by establishing a school of chiropody here in Ontario, we may expect to increase the supply of the main types of chiropodist services. But it is not necessary to this end to sacrifice the additional skills of the U.S. type of practitioner. It should be noted in this regard that the adoption of the British standard of chiropody and the establishment of a school is not going to produce instantly any large number of British standard chiropodists. Although a few chiropodists trained in Britain or in other countries with similar standards will probably offer themselves for licensing, it will be at least four years before any graduates of the new Ontario school become available. During this period we will remain heavily dependent for foot care on U.S.-trained practitioners.

Accordingly, it would be my suggestion that the present Chiropody Act be amended, and that henceforth it be known as the Podiatry Act. In its amended form it would outline the scope of the practice which we would permit to graduates of accredited U.S. podiatry schools who had qualified for practice in Ontario, and who would henceforth be known as podiatrists. At the same time, there would be enacted a new Chiropody Act which would establish the practice of chiropody on the British model, provide for an educational institution to give courses similar to the British courses, and provide for the licensing of the graduates of such courses and those who had taken similar courses in other countries.

I. R. DOWIE

Minority Opinion on Chapter 20, Osteopaths

I am unable to accept the position taken by my colleagues that the question of licensing osteopaths to practice medicine in Ontario should await the time when "it can be said objectively that the quality of education obtained by an osteopath in the United States is equivalent to the quality of education obtained by physicians in the United States whose qualifications the College of Physicians and Surgeons of Ontario accepts". The problem here is one that we and many other bodies in Canada and the United States have encountered in dealing with this and other similar questions. Only physicians and osteopaths have the technical competence to make such an appraisal of the education provided in osteopathic and medical schools, and it is difficult for either to be completely objective in dealing with this question.

The basic question which this Committee is asked to consider is whether or not graduates of the recognized osteopathic schools in the United States are qualified to practice medicine, and the evidence from that country seems to be overwhelming that they are. Some twelve thousand osteopaths are practising medicine in the United States and providing about 10 per cent of family medical health care in that country. The armed services accept Doctors of Osteopathy on the same basis as M.D.'s and grant equal rank to both. Federal and state governments give substantial financial support to osteopathic schools and hospitals, and 2,400 doctors of osteopathy in California were granted M.D.'s without any further education or examination in 1962 when the College of Osteopathic Physicians and Surgeons of California was converted into the California College of Medicine.

On the basis of this evidence I believe that this Committee should make a firm recommendation and not propose a course of action which might well involve the initiation of new studies, such as we have just completed, and renewed tours of inspection of schools of osteopathy by teams of physicians.

It is my recommendation that appropriate measures be taken immediately to license for the full practice of medicine in Ontario those graduates of the recognized schools of osteopathy in the United States who have passed the M.C.C. examinations and completed a year's internship in an accredited hospital either in the United States or in Ontario. I believe that the most satisfactory way of handling this licensure would be the assumption by the College of Physicians and Surgeons of Ontario of responsibility for licensing applicants from these schools in the same way as they license applicants from medical schools in the United States. This is the procedure which has been adopted in the Province of Quebec based on the recommendations of two commissions appointed by the Quebec government, and

it is to be hoped that it could be adopted in Ontario. If for any reason it were found to be impracticable, then I would recommend that a separate Act governing the practice of osteopathy be introduced. This Act would permit the full practice of medicine to graduates of osteopathic schools approved by the Board of Osteopathy who were able to meet the conditions required of graduates of United States' medical schools for licensure in Ontario. Osteopaths qualified in this way would be known as Osteopathic Doctors and would be so licensed by the Ontario Board of Osteopathy, the composition and powers of which would be reviewed in the light of this change. An Act governing osteopathy would be required in any case to cover the practice of those practitioners presently licensed as osteopaths in Ontario who were unable or did not wish to qualify for medical practice who would continue to practise as osteopaths on the limited scope of practice presently permitted.

Whatever method of licensure may be adopted, I believe it is important that there should be a distinction made between graduates of medical schools and those of schools of osteopathy. The view expressed on page 445 that the main distinction between the modern osteopath and the modern medical doctor is that "the osteopath places greater emphasis on the use of manipulation and somewhat less emphasis on drugs than the physician", is certainly not shared by osteopaths, who told us in the submission made to us by the Ontario Board of Osteopathy that there was an important difference in the basic philosophies of the two professions. Be that as it may, it is acknowledged that there is considerable merit in osteopathic manipulative techniques, and the public should be able to identify doctors who are able to provide such treatments.

No proposal was made to us by the representatives of the profession of osteopathy that there should be any educational programs for osteopaths established in Ontario, and none would be recommended.

Treatments provided by osteopathic doctors would be covered by OHSIP in the same way as those provided by medical doctors. Osteopathic doctors should have the same eligibility for hospital privileges as M.D.'s.

The classification "Osteopath" would be limited to those at present practising who did not qualify as osteopathic doctors and there would be no new registrations in this classification. This being the case, if the licensure of doctors of osteopathy were to be handled by the College of Physicians and Surgeons the need for a Board of Osteopathy would not be a permanent one.

Manipulative services which licensed "osteopaths" perform and which would be covered by OHSIP if performed by a physician, an Osteopathic Doctor or a physiotherapist should be covered by OHSIP if provided by a licensed "osteopath".

I. R. DOWIE

Minority Opinion on Chapter 21, Chiropractors

I do not believe that it is appropriate to say that the relationship between chiropractic education and the scope of the practice of chiropractors creates a situation which warrants the measures proposed in Recommendations 278, 279 and 281.

If we were starting afresh to recommend the ideal system to make health care available we might very well recommend that all who required health care, with the possible exception of dental health care, should be seen first by a general physician who would make a diagnosis and treat them, or refer them to specialists for further examination or to therapists for treatment. Such a structure is unattainable today, partly for lack of physicians and partly because to legislate that it should replace the existing patterns would be to interfere excessively with what we suggest in Chapter 1 are the rights of individuals. It should, however, be the objective to approximate the ideal as closely as possible, making the best possible health care available, and keeping to a minimum any interference with the right of the individual to select the health care which he wishes to receive.

Recommendation 281 requires any individual who wishes to obtain a manipulative treatment from a chiropractor to first visit a physician and obtain his opinion as to whether or not such a treatment is contra-indicated. Since it is acknowledged in Chapter 21 that we know of no real evidence that people are harmed by chiropractic treatment, I am unable to reconcile this recommendation with our views on the rights of individuals. It may be our judgment, as it is LaCroix's, that medical education is superior to chiropractic education and that a physician is better able to make a differential diagnosis than is a chiropractor, but be this as it may, since there is no evidence of harm we must conclude that, whatever the difference between the two standards, the competence of the chiropractor to diagnose is adequate for the protection of his patients and there is no justification for interfering with the patient's right to receive such treatment as the chiropractor prescribes.

Apart from the question of the acceptability of the interference with the rights of individuals there are several practical problems which of themselves would make me hesitate to support this recommendation. It seems to me that the proposed relationship of the physician and the chiropractor would create great difficulties for each of them and also for the proposed Health Commissioner. There must be a question as to whether the average physician knows enough about chiropractic treatments to be able to say whether or not they are contra-indicated, and if complications should ensue in a case where a physician has detected no contra-indication there would seem to be a question of responsibility.

The chiropractor who had prescribed a treatment would be placed in a difficult position if his patient were advised by a physician that the treatment was contra-indicated. He could concede that he had made an error in judgment, or he could proceed with the treatment if the patient decided to ignore the physician and requested the treatment, or he could protest the case to the Health Commissioner. The third alternative which would protect his professional pride and his relationship with the patient would be likely to be preferred, particularly since with the absence of any evidence of harm to suggest that contra-indicated treatments had been given in the past, it would seem that the burden of proof would be on the physicians.

Under the circumstances, it would be difficult to blame the physician for erring on the side of conservatism or the chiropractor for challenging unfavourable opinions. If only a small number of the physicians and chiropractors responded in this way, it would give the Health Commissioner many difficult cases to resolve and might well give the impression that the physicians were being obstructive in the way which it is suggested in Chapter 21 would make the plan unworkable.

It is possible that over a period a new type of chiropractor, the product of the reformed chiropractic education suggested in Recommendations 278 and 279, would adapt to the proposed relationship and would enjoy the confidence of the medical profession to a greater extent than does the chiropractor of today. But Recommendation 281 would govern the present practitioners, the product of traditional chiropractic education, and also their patients who would be likely to consider themselves the victims of very considerable interference if they were unable to obtain treatment until a disputed case was resolved.

The existing restriction on the clinical psychologist that he may not proceed with a treatment until the patient has been examined by a physician is not really a parallel. It is generally acknowledged that mental disorders may have physical origins and there is nothing in the psychologist's education to enable him to diagnose such cases. The chiropractic curriculum includes 954 hours of diagnosis and, as we have said above, the record seems to suggest that this does equip them to detect contra-indication.

If the "ideal" situation cannot be established by legislation it would seem that the best approach to it would be to provide a satisfactory alternative to chiropractic and to educate the public to prefer it. There is a growing acceptance of the merits of chiropractic manipulation and it would seem to be in the public interest that it should be made available, provided by therapists who would not have spent the years required for a medical education or a chiropractic education but in perhaps the three years of education and training required for physiotherapy, supplemented if additional time were required, would have mastered the chiropractic techniques. These, like a physiotherapist, they would apply only on the prescription of a physician.

It would be most desirable that there be associated with this education and training of therapists medical research to establish the true scientific basis of this therapy and its scope. It would be hoped that chiropractors would participate in the research and teaching, and that chiropractic education would benefit from the research no less than medical education and the education of the therapists. In this way it is possible that over a period the differences in the beliefs of physicians and chiropractors might be eliminated and chiropractic education could be provided in a university, or chiropractic schools could qualify for government financial assistance.

The intent of Recommendations 278 and 279 is similar to the above proposal. Through the provision of reformed chiropractic education in CAAT's or similar institutions a new type of chiropractor would be produced who would treat patients only when they had been examined by a physician. Only the graduates of these "reformed" courses would be licensed to practise as chiropractors in Ontario although undoubtedly those chiropractors at present practising would be licensed to continue to practise subject to the restriction proposed in Recommendation 281.

This proposal has the same disadvantage as Recommendation 281 in that over a period it would deprive a portion of the public of a source of health care which they prefer, without the justification that it has been shown to be harmful. One system of providing chiropractic manipulation may produce better health care than the other, but as long as neither are harmful, the public should be free to choose.

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